

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please carbon copy pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

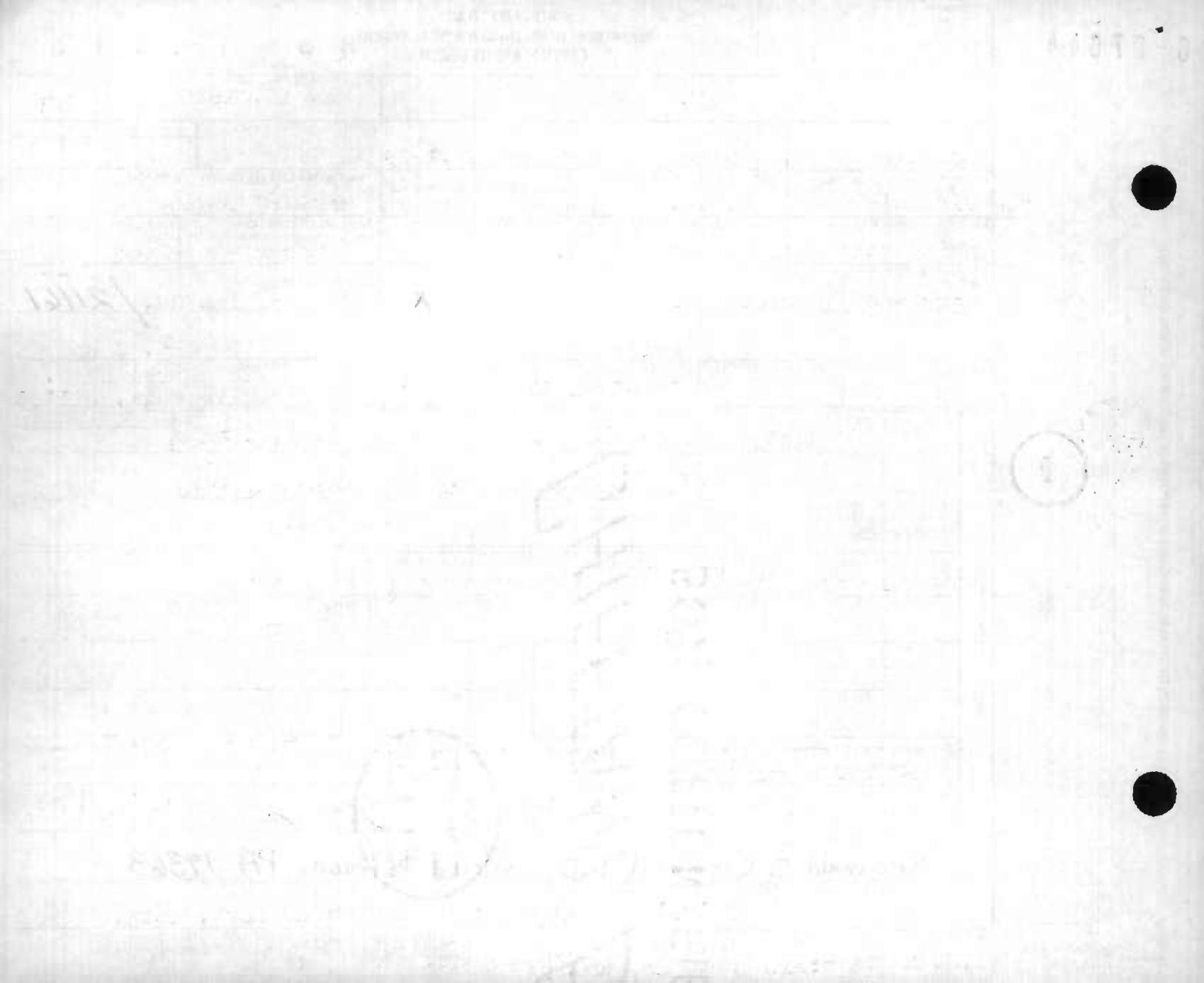
158

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 14613

REG. NO.

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|------------|
| 1. DECEASED NAME (TYPE OR PRINT) IDA V. ALLOWAY | | | 2a. DATE OF DEATH May 16, 1986 | MONTH YEAR | DAY | 2b. HOUR 1:30 P.M. | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR August 27, 1920 | 6. AGE (IN YEARS LAST BIRTHDAY) 65 | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. | | | | |
| 10. CITY OR TOWN OF DEATH White Hall | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2504 Harkins Rd. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Food Processing | |
| 13a. STATE Maryland | 13b. COUNTY Harford | 13c. CITY OR TOWN White Hall | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 2504 Harkins Rd. /21161 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jeff Price | 15. MOTHER'S MAIDEN NAME Josephine | | | 16. ADDRESS 2504 Harkins Rd. White Hall, MD 21161 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | 16b. SOCIAL SECURITY NO. 168-14-381 | 17. INFORMANT Harry E. Alloway | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic Cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>disease</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Chronic Hypertension Pulmonary Disease</u> | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | 21g. CITY OR TOWN | | 21h. COUNTY | | 21i. STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/30</u> to <u>5/16/86</u> , that (I) (we) last saw the deceased alive on <u>4/30</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Reginald B. Gemmill MD</u> | 22c. DEGREE M.D. | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22e. DATE SIGNED 5/16/86 | | | | |
| 22e. HOSPITAL'S NAME (TYPE OR PRINT) <u>Reginald B. Gemmill MD</u> | 22f. ADDRESS <u>Stewartstown, PA 17363</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE May 19, 1986 | 23c. NAME OF CEMETERY OR CREMATORIAL Centre Presbyterian Cemetery | 23d. LOCATION CITY OR TOWN New Park, York, | 23e. COUNTY PA | | 23f. STATE PA | |
| 24. FUNERAL DIRECTOR NAME <u>J.J. Hartenstein</u> | 24b. ADDRESS Second at Franklin St. New Freedom, PA | 24c. DATE RECEIVED BY REGISTRAR May 22, 1986 | | | 24d. REGISTRAR'S SIGNATURE <u>J.J. Hartenstein</u> | | |



00-07117

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copy in Pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other illusive event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 8 | 6 | 1 | 4 | 6 | 1 | 4 | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------|---|---|---------------------------------------------------------------------------------------------------------------------------------------|---|-------|-----------------------------------------------------------------------------|------|----------|--------------------------------------------------|--|--|
| | | | | | | | | | | | | REG. NO. | | | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST JOHN | | | MIDDLE OLIVER | | | LAST ALLUM | | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | | | |
| | | | | | | | | | | | | | | | May 17, 1986 | | | | | 9:55 PM | | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 7. AGE (IN YEARS LAST BIRTHDAY) | | | 8. IF UNDER 1 YEAR MONTHS DAYS | | | 9. IF UNDER 24 HRS HOURS MIN. | | | | | | | | |
| | | | | | | July 31, 1895 | | | 90 | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Portsmouth, England | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County | | | 10. CITY OR TOWN OF DEATH Bel Air | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber | | | 12b. KIND OF BUSINESS OR INDUSTRY Railroad | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Harford | | | 13c. CITY OR TOWN Bel Air | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 318 Maitland Street 21014 | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST George | | | MIDDLE Oliver | | | LAST Allum | | | 15. MOTHER'S MAIDEN NAME FIRST Agnes | | | MIDDLE — | | | LAST Britten | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | | 17. INFORMANT 715-14-1962 | | | 17. ADDRESS Mrs. Betty A. Wallett, 318 Maitland Street | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | | | Cardio respiratory failure | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart & dehydration | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) refusal to take fluids by mouth | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | Congestive heart failure as a result of | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 19c. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20a. DATE OF OPERATION | | | 20b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20c. AUTOPSY? | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | | | STATE | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from <u>April</u> 19 86 to <u>May</u> 19 86, that (I) we last saw the deceased alive on <u>May</u> 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Robert A. Duncan, M.D. | | | | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 5-18-86 | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Duncan, M.D. | | | 22e. ADDRESS 1131 Bel Air Road, Bel Air, Md. 21014 | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE May 18, 1986 | | | 23c. NAME OF CEMETERY OR CREMATORIUM R.A. Ferris Crematory | | | 23d. LOCATION CITY OR TOWN W. Chester | | | 23e. COUNTY Chester | | | 23f. STATE Pa. | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009 | | | 25a. DATE REC'D. BY REGISTRAR MAY 20 1986 | | | 25b. REGISTRAR'S SIGNATURE John M. McComas III | | | | | | | | | | | | | | | | | |
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MEDICAL CERTIFICATION

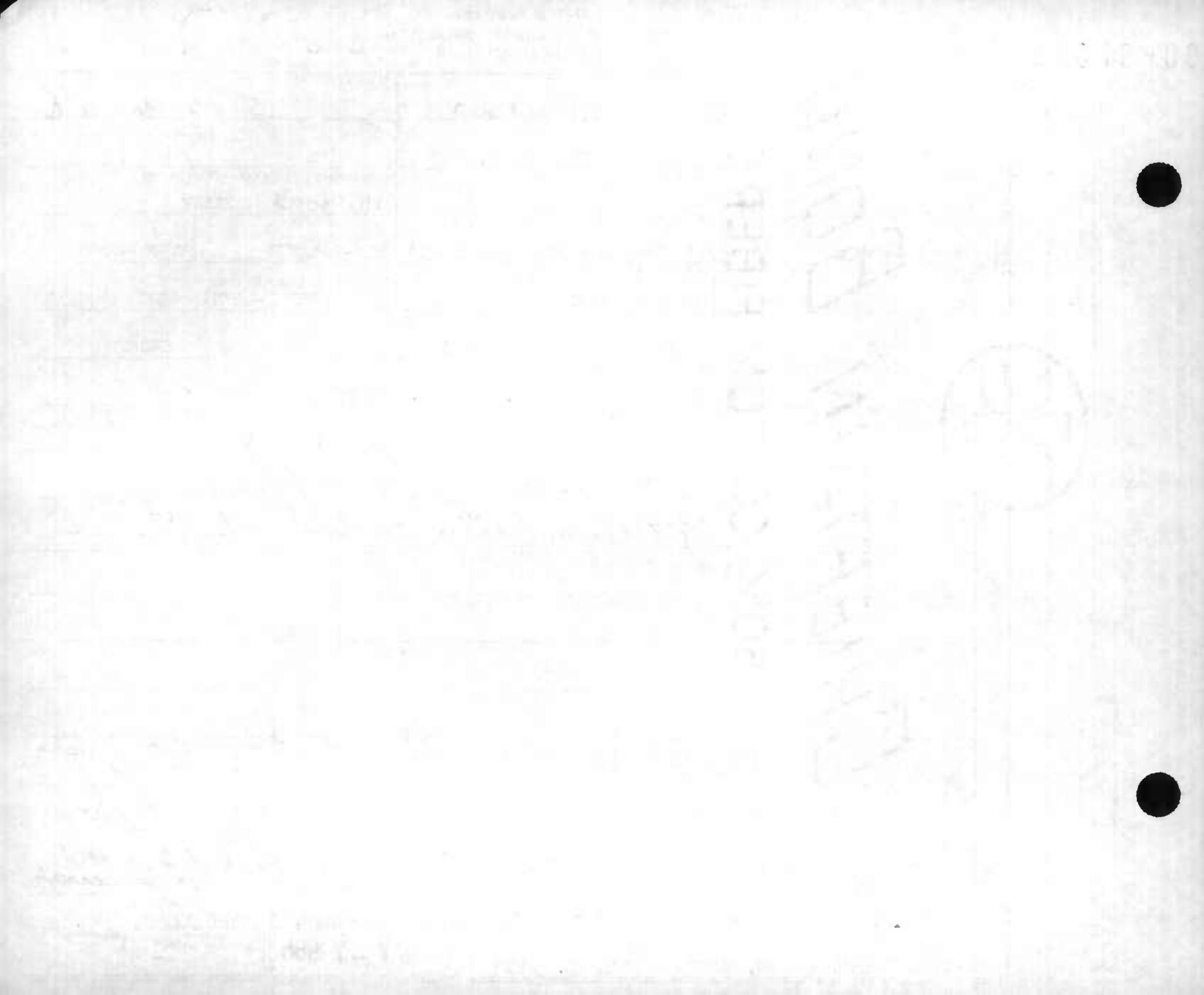
1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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| 1. DECEASED NAME (TYPE OR PRINT) | | | LAST | | | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| Deedie DAN Anderson | | | | | | 5 23 86 | 5 23 | 86 | 10 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| MALE | | WHITE | | DECEMBER 19, 1900 | | | 85 YRS. | | IF UNDER 12 HRS HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| virginia | | USA | | | | | Harford COUNTY | | SELF-EMPLOYED | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Havre de Grace | | Harford Memorial Hospital | | MD HARFORD HAVRE de GRACE | | | DAIRY FARMER | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| MD | | HARFORD | | HARFORD | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4104 WEBSTER-LAPIUM ROAD 21078 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | |
| GRANVILLE | | POLLY SPENCER | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| NO | | 212 18 9022 | | MRS. CARRIE S. ANDERSON | | | SAME AS #13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 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598, 599, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 790, 791, 792, 793, 794, 795, 796, 797, 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998, 999, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1080, 1081, 1082, 1083, 1084, 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1161, 1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1310, 1311, 1312, 1 | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please return this paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8614616 | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------|--------|---------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------|----------|-------|-------------------------------------------------|--|
| | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| Walter P. Paul | | | | | Bananto | MAY 27 1986 | | | 7 P | 20 | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | |
| Male | | | white | | | MONTH April 6, 1927 DAY YEAR | | | 59 | | | MONTHS DAYS | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 8. IF UNDER 4 HRS | |
| McIntyre, Pa. | | | USA | | | | | | Harford | | | MONTHS DAYS | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Harve de Grace | | | Harford Memorial Hosp | | | Mechanic | | | Telephone | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS / ZIP CODE | | | | |
| Md. | | | Harford | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 3927 Pulaski Highway 21009 | | | | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | MIDDLE | LAST | | | |
| Joseph | | | John | | Bananto | Nellie | | | Debbie | Zajac | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | |
| Yes | | | 198-20-3061 | | | Mrs. Mildred Bananto, 3927 Pulaski Highway | | | Abingdon, Md. 21009 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for items (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| (b) <u>Severe Coronary artery disease</u> | | | | | | | | | | | | | |
| (c) <u>Arteriosclerosis</u> | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-27 1986, to 5-27 1986, that (I) (we) last saw the deceased alive on 5-27 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | 22c. DATE SIGNED 5/28/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | | | | |
| DANTE MONARIL | | | Harve de Grace, Md 21078 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIUM | | | 23d. LOCATION CITY OR TOWN | | | | |
| Burial | | | May 30, 1986 | | | Crest Lawn Cemetery | | | Marriottville Howard Md. | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Howard K. McComas III, Abingdon, Md. 21009 | | | | | | IN 2 1986 | | | Howard McComas | | | | |

12180-1



TO HOSPITAL OR ATTENDING PHYSICIAN: the
retained by the hospital or attending physician.

The death sentence may be executed within 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial permit. Then print out carbon copies, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 and any injury, or other traumatic event, the medical examiner may be notified in place of the physician.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) TERRENCE ENOCH BILLINGS | | | 2a. DATE OF DEATH MAY 4 86 | MONTH MAY | DAY 4 | YEAR 1986 | 2b. HOUR 10 AM | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH 6 DAY 2 YEAR 11 | 6. AGE (IN YEARS LAST BIRTHDAY) 74 | IF UNDER 1 YEAR MONTHS 0 | | IF UNDER 24 HRS. HOURS 0 MIN. 0 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oregon | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH FOREST HILL | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1700 Baldwin Mill Rd. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHYSICIAN | | | | | 12b. KIND OF BUSINESS OR INDUSTRY MEDICAL | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | 13b. COUNTY HARFORD | 13c. CITY OR TOWN FOREST HILL | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS, ZIP CODE 1700 BALDWIN MILL RD 20901 | | | |
| 14. FATHER'S NAME FIRST Terrence | | | MIDDLE E. | LAST Billings | 15. MOTHER'S MAIDEN NAME FIRST Kate | MIDDLE | LAST Gregory | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 438 56 2216 | | 17. INFORMANT ADDRESS 1700 Ms. Ellen Scully Baldwin Mill Rd. Forest Hill, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs | | | | | | |
| (b) PARTHYPLEGIA | | | 4 yrs | | | | | | |
| (c) CERVICAL SPONDYLOSIS | | | 4 yrs | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | | COUNTY | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from ARRIL 1982 , to 5/4 1986 , that (I) (we) lost saw the deceased alive on 5/4 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Emory Linder MD</i> | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> | MEDICAL DIRECTOR <input type="checkbox"/> | STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 5/4/86 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EMORY LINDER | 22e. ADDRESS 902 AUGUSTA RD, JOPPA MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | 23b. DATE 5-4-86 | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS BALTO., MD. | 23d. LOCATION CITY OR TOWN | 23e. COUNTY | | STATE | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | 25a. DATE REC'D. BY REGISTRAR MAY 07 1986 | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i> | | | | | | | |

0-06361

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8614018
REG. NO.1. FOR
STATE
REGISTRAR

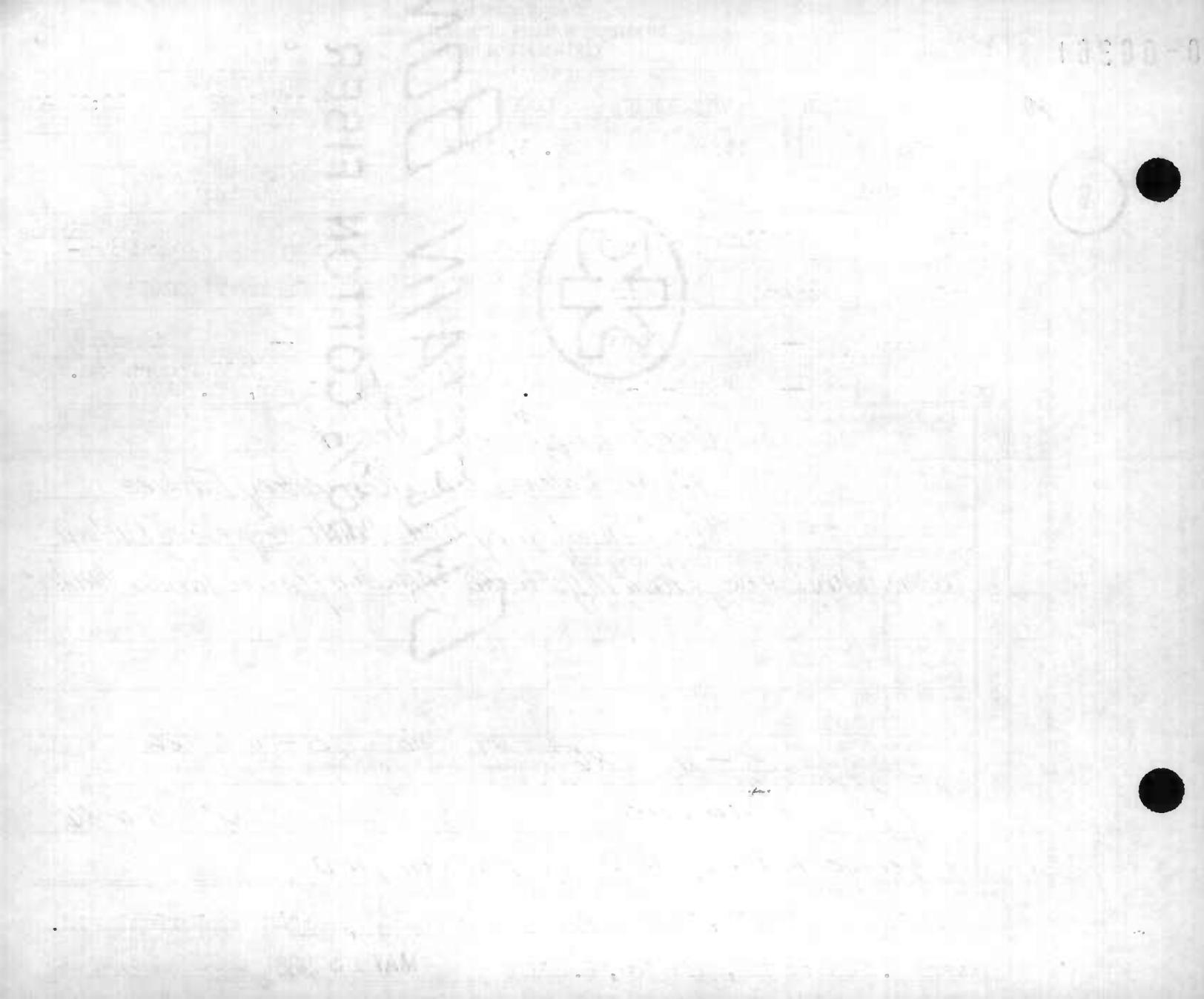
| | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------|-----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | MONTH | DAY | YEAR | 2b HOUR | | |
| PAUL | | | VAN BUREN | | BOGGS | May 11, 1986 | | | | 10:21 AM | | |
| 3. SEX | | 4 RACE | 5. DATE OF BIRTH | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 YEAR | | 8 IF UNDER 24 HRS | | |
| Male | | White | Nov. 1, 1903 | | | 82 | | MONTHS | DAYS | HOURS | MIN. | |
| YRS. | | | | | | | | | | | | |
| 7c BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| West Virginia | | USA | | | | | Harford County | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | |
| Fallston | | Fallston General Hospital | | | Repairman | | Appliance Furniture- | | | | | |
| 13a STATE Maryland | | 13b COUNTY Harford | | 13c CITY OR TOWN Bel Air | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 503 Vale Road 21014 | | | | |
| FATHER'S NAME FIRST Andrew | | MIDDLE — | | LAST Boggs | | 15. MOTHER'S MAIDEN NAME FIRST Nettie | | MIDDLE — | | LAST Simmons | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17 INFORMANT | | ADDRESS | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| no | | 215-01-4720 | | P. Harold Boggs, Bel Air, Md. 21014 | | 1317 Locust Ave. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hyperkalemia and Respiratory Failure</i> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Renal Insufficiency and Adult Respiratory Distress</i> | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Urinary Kidney Disease, Recent Myocardial Infarction, Facial Nerve Accident</i> | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-11-86 to 5-11-86, that (I) (we) last saw the deceased alive on 5-11-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <i>George Laws, M.D.</i> | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> | | MEDICAL DIRECTOR <input type="checkbox"/> | | STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22d. DATE SIGNED 5-11-86 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>George Laws, M.D.</i> | | 22f. ADDRESS <i>Fallston, MD.</i> | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE May 13, 1986 | | 23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens, Bel Air | | 23d. LOCATION CITY OR TOWN Bel Air | | CITY OR TOWN Harford | | COUNTY Md. | | |
| 24 FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009 | | ADDRESS | | 25b. DATE REC'D. BY REGISTRAR MAY 13 1986 | | 25b. REGISTRAR'S SIGNATURE <i>Howard K. McComas III, Abingdon, Md. 21009</i> | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by 1, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

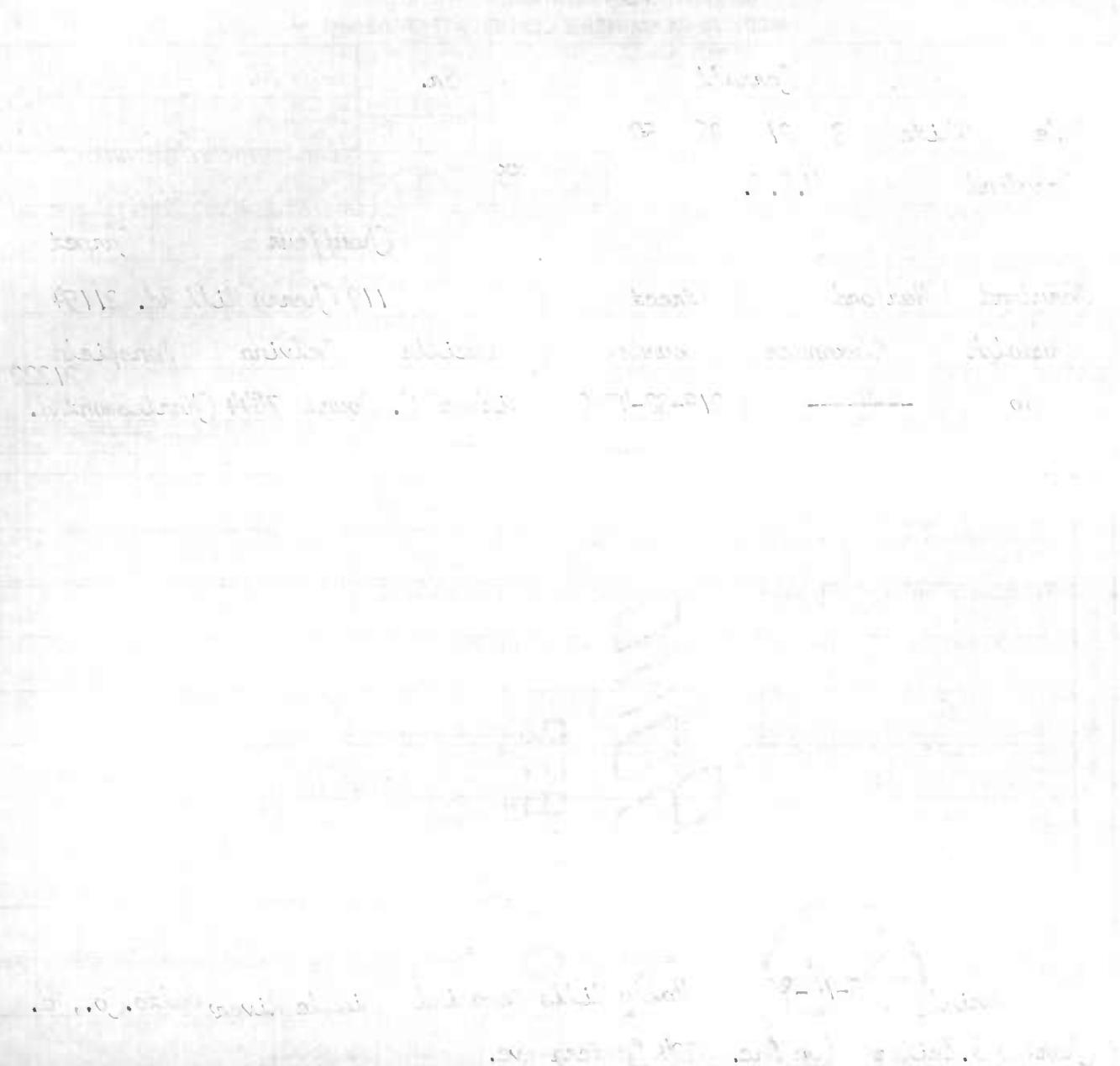
BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 6 1 4 6 1 9 | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------|---------------------|------------------|------------------------------|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------|-------|-----|------|----------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE KNOWN OF ESTI- MATED | MONTH | DAY | YEAR | 2b. HOUR |
| JOSEPH | | | Carroll | | | Bounds | | | Sr. | | | <input checked="" type="checkbox"/> | 5 | 7 | 1986 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. MARRIED | 10. CITIZEN OF WHAT COUNTRY? | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Male | White | 3 21 36 | 50 yrs. | MONTHS | DAYS | XX NEVER MARRIED | U.S.A. | 119 Cherry Hill Rd. | Chauffeur | Carpet | | | | | | |
| 10. CITY OR TOWN OF DEATH Street | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| MARYLAND | 119 Cherry Hill Rd. | Chauffeur | Carpet | | | | | | | | | | | | | |
| 13a. STATE Maryland | 13b. COUNTY Harford | 13c. CITY OR TOWN Street | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 119 Cherry Hill Rd. 21154 | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST: Rudolph | MIDDLE: Alexander | LAST: Bounds | 15. MOTHER'S MAIDEN NAME FIRST: Lucille | MIDDLE: Melvina | LAST: Mansfield | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. 219-32-4769 | 17. INFORMANT Richard C. Bounds | ADDRESS 21222 7844 Charlesmont Rd. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple gunshot wounds of head (handgun)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:30XX 5-7- 1986 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot. | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house | 21f. LOCATION STREET 119 Cherry Hill Rd., Street, | CITY OR TOWN | COUNTY | STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an death resulted from <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | 22b. TITLE (SPECIFY) Assistant | 22c. MEDICAL EXAMINER | | | | | | | | | | | | | | |
| 23a. EXAMINER'S NAME (TYPE OR PRINT) | 23b. ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | DATE SIGNED 5-8-86 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE 5-10-86 | 23c. NAME OF CEMETERY OR CREMATORIAL Holly Hills Memorial | 23d. LOCATION CITY OR TOWN Middle River, Balto., Co., Md. | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc. | ADDRESS 6224 Eastern Ave. | 25a. DATE REC'D. BY REGISTRAR MAY | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| 20M 4/22 | | | | | | | | | | | | | | | | |



00-08525

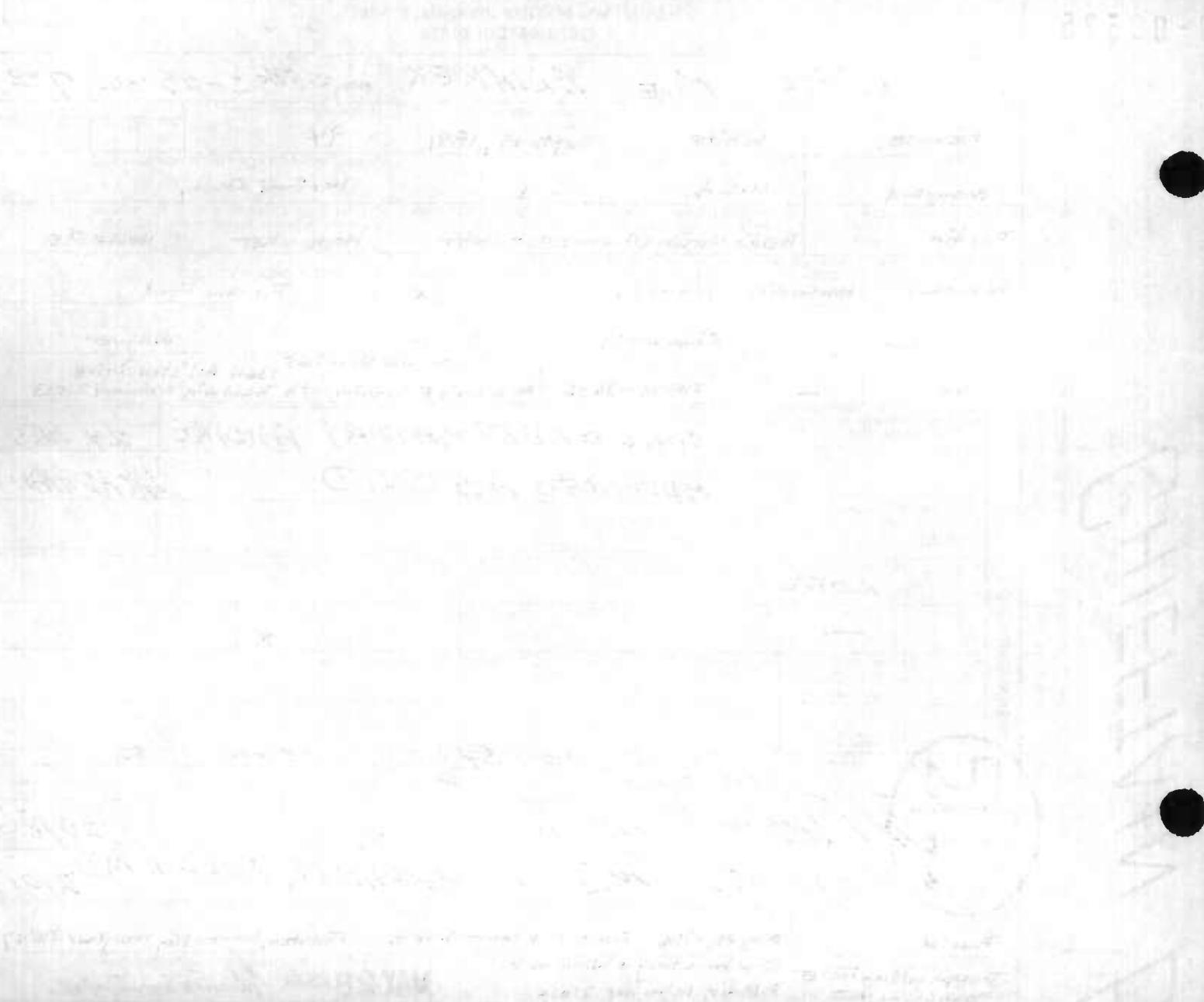
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other transitory event, the medical examiner must be informed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 6 1 4 6 2 0 | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|------|------------------------|--|
| | | | | | | | | | | REG. NO. | | | | | |
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | | MIDDLE | | LAST | | 2d. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| | | EFFIE MAE BINKER | | | | | | | MAY 25, 1986 | | 5 | 25 | 86 | 7:00 M | |
| 3. SEX | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| FEMALE | | White | | | SEPT, 19, 1891 | | | 94 | | YEARS | | MONTHS DAYS | | HOURS M.N. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD. | | | |
| Maryland | | U.S.A. | | | | | | | | Harford County | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH EACHLY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Bel Air | | Bel Air Nursing & Convalescent Center | | | | | | HOMEMAKER | | Housewife | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13b. STREET ADDRESS / ZIP CODE | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Harford Co. | | 13c. CITY OR TOWN Forest Hill | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | 91050 | | | | | |
| YES <input type="checkbox"/> | | NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> | | NO <input checked="" type="checkbox"/> | | Putnam Road | | | | | | | |
| 14. FATHER'S NAME FIRST William | | MIDDLE | | LAST CHENWORTH | | 15. MOTHER'S MAIDEN NAME Emma | | MIDDLE | | LAST WAGNER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 16c. INFORMANT (Daughter) 592-7165 ADDRESS | | 16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| NO | | 218-26-3436 | | Mrs. Doris E. Wentworth Baldwin, Maryland 21013 | | 24 HRS | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | MORE THAN 1/2 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED A.S.C.V.D. | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9:00 57, 19, to 25 MAY, 19, 86, that (I) (we) last saw the deceased alive on 4/18/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE H. P. SIDWELL M.D. | | | | | | | | | | 22c. DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | DATE SIGNED 5/25/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. P. SIDWELL M.D. | | 22e. ADDRESS 401 FRANKLIN ST. BEL AIR, MD 21014 | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 28, 1986 | | 23c. NAME OF CEMETERY OR CREMATORIAL Facility Fallston Methodist Ch. Cem. | | 23d. LOCATION CITY OR TOWN Fallston, Harford Co., Maryland 21047 | | | | |
| 24. FUNERAL DIRECTOR Joseph William Foster 50 W. Broadway & Williams St. Bel Air, Maryland 21014 | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR MAY 28 1986 | | 25b. REGISTRAR'S SIGNATURE Julia L. Rendell | | | | | | | | |



462

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER (HOSPITAL) WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TOMB STONE. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 501 W. PRESTON STREET, BETHANY, MARYLAND. **TO CEMETERY OR CREMATORIUM:** RETAIN PAGES 1, 2, AND 3.

DIVISION OF VITAL RECORDS 301 W. BENTON ST. DIVISION NO. 21261

| | | | | | | | | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------|------------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------------|-------------------------------------------------------------------------------|--------------------------|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------|---------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Michael | | | MIDDLE Stephen | | | LAST Butz | | | 2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> 5 10 19 86 | | | 2b. HOUR M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. YRS. | 9. DATE PRONOUNCED DEAD | 10. MONTH DAY YEAR | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | 13. CITY OR TOWN OF DEATH Fallston | 14. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 15. CITIZEN OF WHAT COUNTRY? U.S.A. | 16. MARRIED WIDOWED DIVORCED | 17. BALTIMORE CITY OR COUNTY OF DEATH Harford County | 18. DATE REC'D. BY REGISTRAR MAY 15 1986 | 19. REGISTRAR'S SIGNATURE John Smialek | |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13a. STATE Md. | | | 13b. COUNTY Harford | | | 13c. CITY OR TOWN Fallston | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS 1106 Peachtree Rd. 21047 | | | |
| 14. FATHER'S NAME FIRST Norman | | | MIDDLE John | | | LAST Butz Jr. | | | 15. MOTHER'S MAIDEN NAME Helen | | | 16. SOCIAL SECURITY NO. 216-92-7530 | | | 17. INFORMANT Helen Butz (mother) same address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8150 IMMEDIATE CAUSE (a) Cranio-cerebral trauma Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MD | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:25 AM 5/10 1986 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | driver/auto/fixed object impact | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Roadway | | | 21f. LOCATION STREET Karen Drive, Kingsville, Harford County, MD | | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> | | | and in my opinion | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John E. Smialek</i> | | | TITLE (SPECIFY) Chief M.D. | | | MEDICAL EXAMINER | | | DATE SIGNED May 10, 1986 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | John E. Smialek, MD | | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5/13/86 | | | 23c. NAME OF CEMETERY OR CREMATORIUM Highview Cemetery | | | 23d. LOCATION CITY OR TOWN Baltimore | | | COUNTY | | STATE Md. | | | | |
| 24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 9705 Belair Rd. Balto. Md. 21236 | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 15 1986 | | | 25b. REGISTRAR'S SIGNATURE John Smialek | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be mailed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Then please attach this form to the burial permit. Then please attach this form to the burial certificate with the State Dept. of Health and Mental Hygiene given to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, this section must be completed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 6 | 1 4 0 2 2 | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|-----------|------|----------|
| | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 20. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| GWENDOLYN | | LUCY | | | | CARNWATH | | May 13, 1986 | | | | | 10:00 AM |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Month Day Year Feb. 14, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE Country Hampshire, England | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 11. KIND OF BUSINESS OR INDUSTRY -- | | | |
| 10. CITY OR TOWN OF DEATH Edgewood | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2309 Rosewood Drive | | 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Pennsylvania | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 519 Central Avenue 19083 | | 12b. KIND OF BUSINESS OR INDUSTRY -- | | | |
| 13b. COUNTY Delaware | | 13c. CITY OR TOWN Havertown | | 13f. FIRST Sarah | | 13g. MIDDLE -- | | 13h. LAST Morris | | | | | |
| 14. FATHER'S NAME First William | | 15. MIDDLE -- | | 16. LAST Harris | | 17. INFORMANT Albert G. Cobb, 2309 Rosewood Drive, Edgewood | | 18. ADDRESS Md. 21040 | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 16c. 165-30-3043 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 10, 11, and 12) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA, COLON, METASTATIC</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from _____, 19 _____, to _____, 19 _____, that (ii) (we) last saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Andrew Nowakowski</u> | | 22c. DEGREE MD | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> | | 22e. DATE SIGNED 5/13/86 | | | | | | | |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ANDREW NOWAKOWSKI, MD</u> | | 22g. ADDRESS 125 N. MAIN ST. B62 AM, MD 21018 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE May 14, 1986 | | 23c. NAME OF CEMETERY OR CREMATORIAL R.A. Ferris Crematory | | 23d. LOCATION CITY OR TOWN W. Chester | | CITY OR TOWN Chester | | STATE Pa. | | | |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009 | | 25a. DATE REC'D. BY REGISTRAR MAY 15 1986 | | 25b. REGISTRAR'S SIGNATURE <u>John Anderson</u> | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then place entire certificate in papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, or certificate is removed.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or either circumstance occurs,

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 6 2 3
REG. NO.

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| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | | | | | |
| ROBERT L. DAVIS | | | | | | | 5 | 19 | 86 | 4:10pm | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | | | | | |
| Male | | Black | | Month Day Year Jan. 26, 1905 | | | 81 | | | MONTHS DAYS | | | | | | |
| 8. IF UNDER 24 HRS. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| HARFORD | | HARFORD | | MD. | | HAVRE de GRACE | | | CITIZENS NURSING HOME | | | Laborer | | | Stone Quarry | |
| 13a. STATE Maryland | | | | 13b. COUNTY Kent | | 13c. CITY OR TOWN Chestertown | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 400 High Street 21620 | | | | |
| 14. FATHER'S NAME FIRST unknown | | | | MIDDLE | | 15. MOTHER'S MAIDEN NAME LAST unknown | | | | | | | | | | |
| 6a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO OR UNKNOWN | | 6b. SOCIAL SECURITY NO. No | | 16b. SOCIAL SECURITY NO. 218-03-2928 | | | 17. INFORMANT Gary Gunther, Chestertown, Maryland. 21620 | | | ADDRESS | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA OF PROSTATE | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>5/19</u> to <u>May 19 85</u> , to <u>May 19 86</u> , that (1) (we) last saw the deceased alive on <u>1986</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DEGREE | | ATTENDING PHYSICIAN | | MEDICAL DIRECTOR | | STAFF PHYSICIAN | | 22d. DATE SIGNED 5/20/86 | | | | | | |
| John D. Yur | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | Havre de Grace, Md | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORI | | 23d. LOCATION CITY | | 23e. COUNTY | | | | | | | | |
| Burial | | May 23, 1986 | | Cokesbury Cemetery | | Port Deposit, Cecil, Maryland. | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Name | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | |
| Dee Patterson | | on, Perryville, Maryland. | | MAY 28 1986 | | John D. Yur | | | | | | | | | | |

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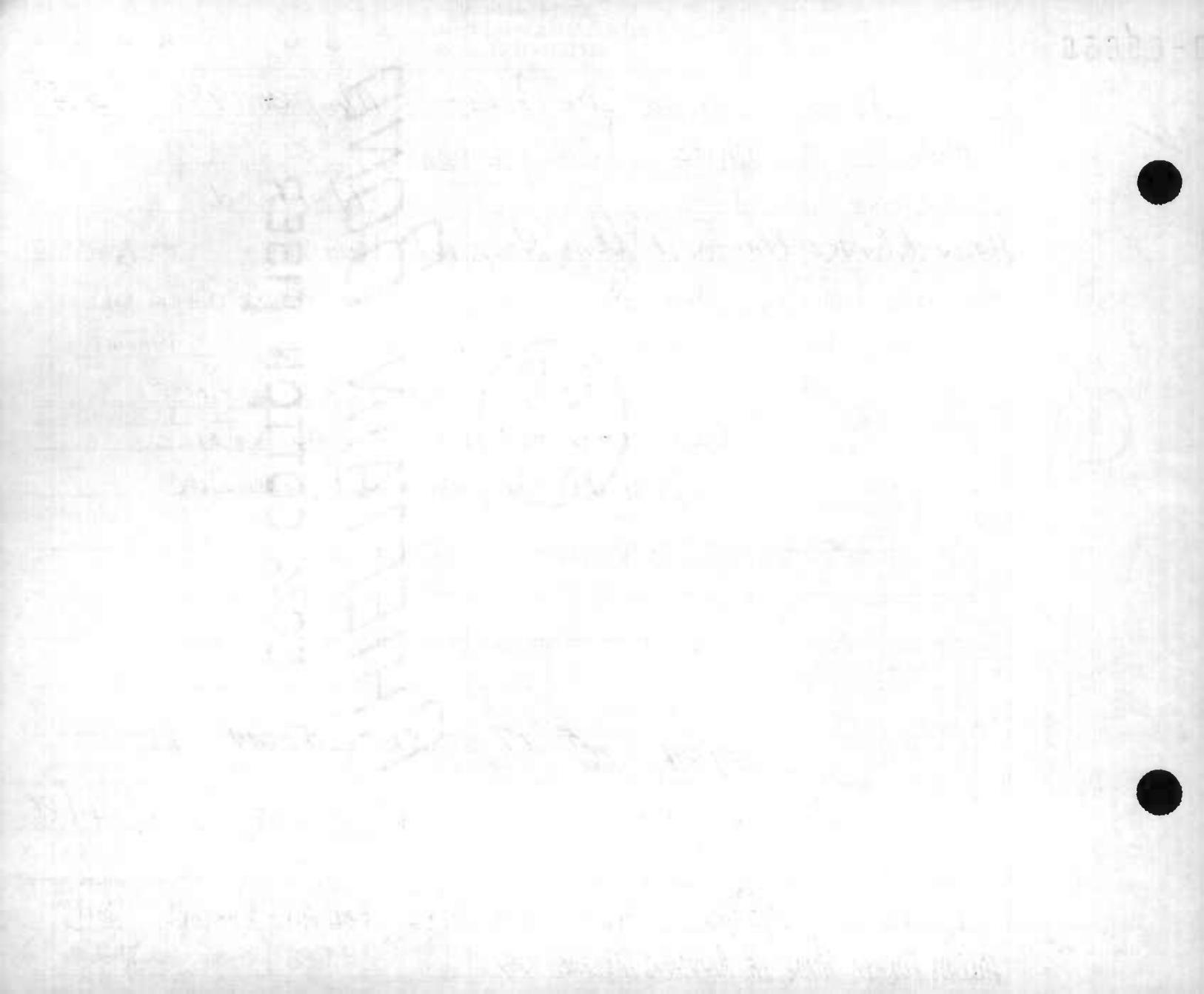
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH80 14624
REG. NO.1 - FOR
STATE
REGISTRAR

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a DATE OF DEATH MONTH DAY YEAR | | | 2b HOUR <u>5 PM</u> | | | | |
| John Alfred De Priest | | | | | | May 24, 1986 | | | | | | | |
| 3 SEX <u>Male</u> | | 4 RACE <u>White</u> | | 5 DATE OF BIRTH MONTH <u>JUNE</u> DAY <u>21</u> YEAR <u>1910</u> | | | 6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS | | IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> | | IF UNDER 24 HRS HOURS <u>0</u> MIN. <u>0</u> | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>PENNSYLVANIA</u> | | 7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>HARFORD</u> | | | MD. | | | |
| 10 CITY OR TOWN OF DEATH <u>Havre de Grace</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HARFORD Mem Hospital</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>MACHINIST</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>US Gorit.</u> | | | | | | |
| 13a STATE <u>MARYLAND</u> | | 13b COUNTY <u>HARFORD</u> | | 13c. CITY OR TOWN <u>ABERDEEN</u> | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE <u>128 BEAUMAIS RD. / 21001</u> | | | | |
| 14 FATHER'S NAME FIRST <u>JOHN</u> | | MIDDLE <u></u> | | LAST <u>DE PRIEST</u> | | | 15. MOTHER'S MAIDEN NAME FIRST <u>EUPHEMIA</u> | | MIDDLE <u></u> | | LAST <u>MORAN</u> | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>YES</u> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>1930's</u> | | 17 INFORMANT <u>M. M. DE PRIEST</u> | | | ADDRESS <u>SAME AS ABOVE</u> | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung - metastases</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD. - permanent pacemaker</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>3/24/86</u> to <u>5/17/86</u> , that (I) (we) last saw the deceased alive on <u>3/24/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Brian T. Go</u> | | 22c. DEGREE <u>M.D.</u> | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. DATE SIGNED <u>5/24/86</u> | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>5/28/86</u> | | | 23c. NAME OF CEMETERY OR CREMATORIAL <u>BEL AIR MEM. GDNS.</u> | | 23d. LOCATION CITY OR TOWN <u>BEL AIR, HARFORD,</u> | | | COUNTY | | STATE | |
| 24 FUNERAL DIRECTOR NAME <u>JAPEN'S Funeral Home, PA</u> | | ADDRESS <u>Aberdeen, MD, 21001-3399</u> | | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 29 1986</u> | | 25b. REGISTRAR'S SIGNATURE <u>John Davidson Pendell</u> | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove THIS CERTIFICATE from this DEATH REPORT and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. THIS CERTIFICATE should be retained by the funeral director. Page 3 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____



HOSPITAL OR ATTENDING PHYSICIAN: The

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be used within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

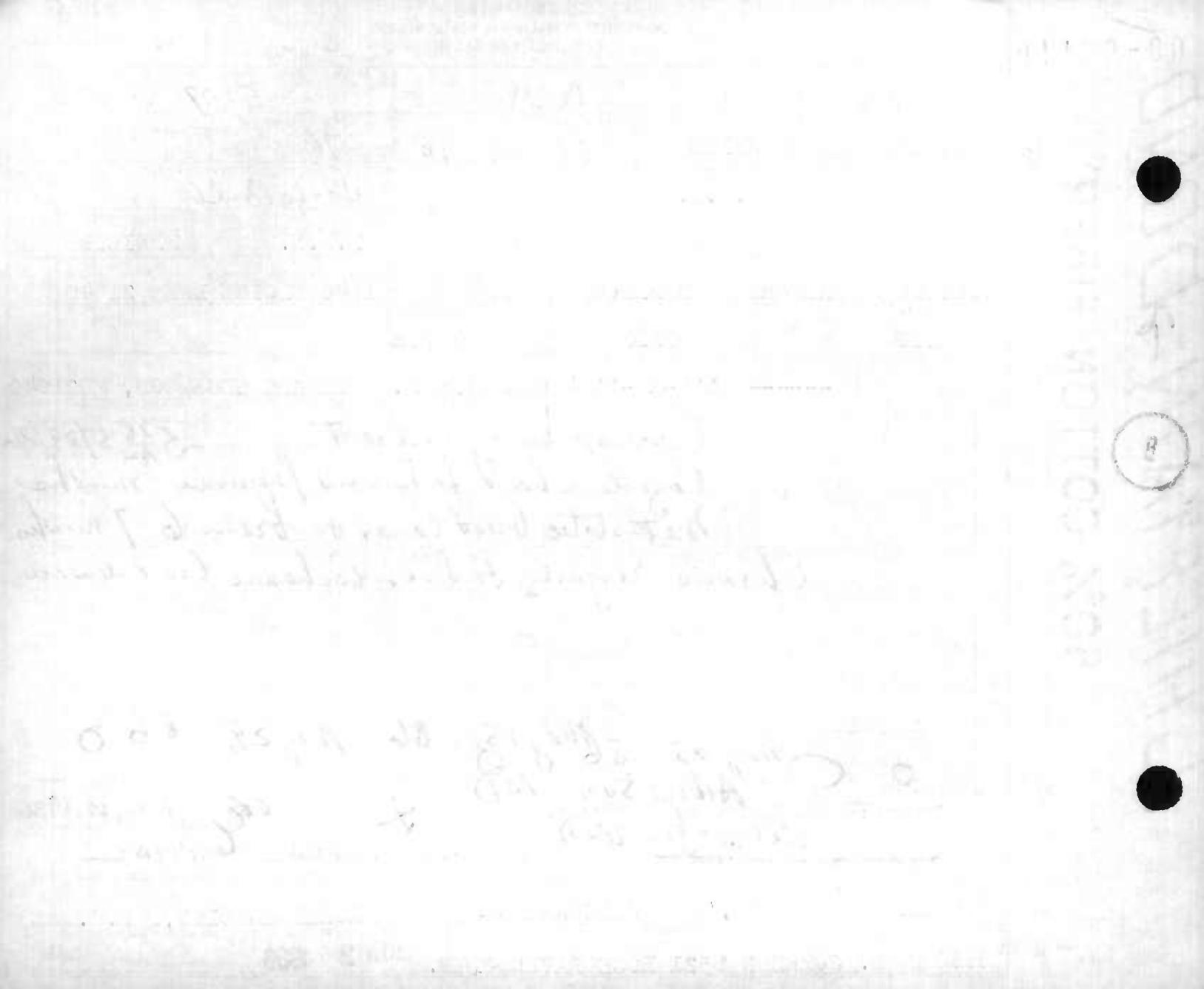
IMPORTANT: If item 2 is marked **B** shows any injury, or other traumatic event, the medical examiner and the police should be called at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REF ID: NC

14025

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) VIRGINIA W. DURM | | | 2a. DATE OF DEATH 5/29/86 | | |
| 3. SEX FEMALE | | 4. RACE WHITE | 5. DATE OF BIRTH MONTH 07 DAY 06 YEAR 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harfard Co. MD. |
| 10. CITY OR TOWN OF DEATH Fallston | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen. Hosp | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) L.P.N. |
| 13a. STATE MARYLAND | | 13b. COUNTY HARFORD | 13c. CITY OR TOWN EDGEWOOD | 13d. INSIDE CITY LIMITS? YES XX NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 1940 ELOISE LANE 21040 |
| 4. FATHER'S NAME FIRST CLEM MIDDLE LAST WILLIS | | 15. MOTHER'S MAIDEN NAME MINNIE | | | |
| 6a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO 237-14-2204 | | 17. INFORMANT MARGARET D. EVERHART | ADDRESS EDGEGOOD, MD 21040 |
| 18. CAUSE OF DEATH (Enter only one cause per line for item 18, and item 19b.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure and Pneumonia Months DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic breast cancer to brain 6-7 months | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5/28 5/29/86 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Chronic respiratory Failure, ischaemic heart disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20b. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II) CITY OR TOWN COUNTY | |
| 21c. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21e. LOCATION STREET CITY OR TOWN COUNTY | |
| 22a. I certify that (b) (this hospital) attended the deceased from May 15, 1986 to May 29, 1986 , that (c) we last saw the deceased May 29, 1986 (d) (our) opinion death occurred on the date and hour and from the causes stated above. (e) (I did not) see the deceased die. | | | | | |
| 22b. SIGNATURE Alan R. Schiowitz, M.D. | | 22c. ATTENDING MEDICAL PHYSICIAN DIRECTOR <input type="checkbox"/> PHYSICIAN | | 22d. DATE SIGNED May 29, 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN R. SCHIOWITZ | | 22e. ADDRESS FALLSTON GENERAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE MAY 31, '86 | 23c. NAME OF CEMETERY OR CREMATORIAL GREENWOOD PARK | | 23d. LOCATION CITY OR TOWN MOREHEAD CITY, N.C. |
| 24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON | | ADDRESS 8521 LOCH RAVEN BLVD. | 25a. DATE REC'D. BY REGISTRAR JUN 2, 1986 | | 25b. REGISTRAR'S SIGNATURE Lea L. Johnson-Rendall |



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00-06080
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | 80 | 14026 | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------|---------------------------|-------------------------|--------------------------|------|
| | | | | REG. NO. | | | | | | | | | | |
| 1 - STATE REGISTRAR | | M/DECEASED NAME (TYPE OR PRINT) | | FIRST <i>hutcher</i> | MIDDLE <i>James</i> | LAST <i>Eggers</i> | 2a DATE OF DEATH <i>May 6 1986</i> | MONTH A | DAY 11:08 AM | YEAR | 2b. HOUR | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH June | | DAY 12 | YEAR 1916 | 6. AGE (IN YEARS LAST BIRTHDAY) 69 | | YRS | IF UNDER 1 YEAR MONTHS | IF UNDER 24 HRS DAYS | IF UNDER 24 HRS HOURS | MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Tennessee</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> | | MD. | | | | |
| 10. CITY OR TOWN OF DEATH <i>Havre de Grace</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Laborer</i> | | | | | | | | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Harford</i> | | 13c. CITY OR TOWN <i>Aberdeen</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <i>9 Aberdeen Ave. / 21001</i> | | | | | | |
| 14. FATHER'S NAME FIRST <i>Robe</i> | | MIDDLE <i></i> | | LAST <i>Eggers</i> | | 15. MOTHER'S MAIDEN NAME FIRST <i>Lizzie</i> | | MIDDLE <i></i> | | LAST <i>Eggers</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> YES | | 16b. SOCIAL SECURITY NO. <i>WW II</i> | | 16c. INFORMANT <i>Rena L. Eggers, Same as Above</i> | | ADDRESS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>CHD</i> <i>As cold</i> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>COPD</i> | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>J. F. Lee.</i> | | 22c. DEGREE <i>M.D.</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED <i>5/6/86</i> | | | | | | | | |
| 22e. ADDRESS <i>Union Med. Clinic, Havre de Grace</i> | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE <i>May 9, 1986</i> | | 23c. NAME OF CEMETERY OR CREMATORIAL <i>Grove Cemetery</i> | | 23d. LOCATION CITY OR TOWN <i>Aberdeen, Harford, Maryland</i> | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Tarring Funeral Home, P.A.</i> | | ADDRESS <i>Aberdeen, MD, 21001-3399</i> | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 9 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>J. F. Lee.</i> | | | | | | | | |

WHO HOSPITAL OR ATTENDING PHYSICIAN The physician retained by the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

in the store Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORBIANI: If item 2 is marked or item 18 shows any injury or other traumatic even

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injury or other traumatic event.

IMPORTANT: If Item 2] is marked or Item 18 shows 000

MEDICAL CERTIFICATION

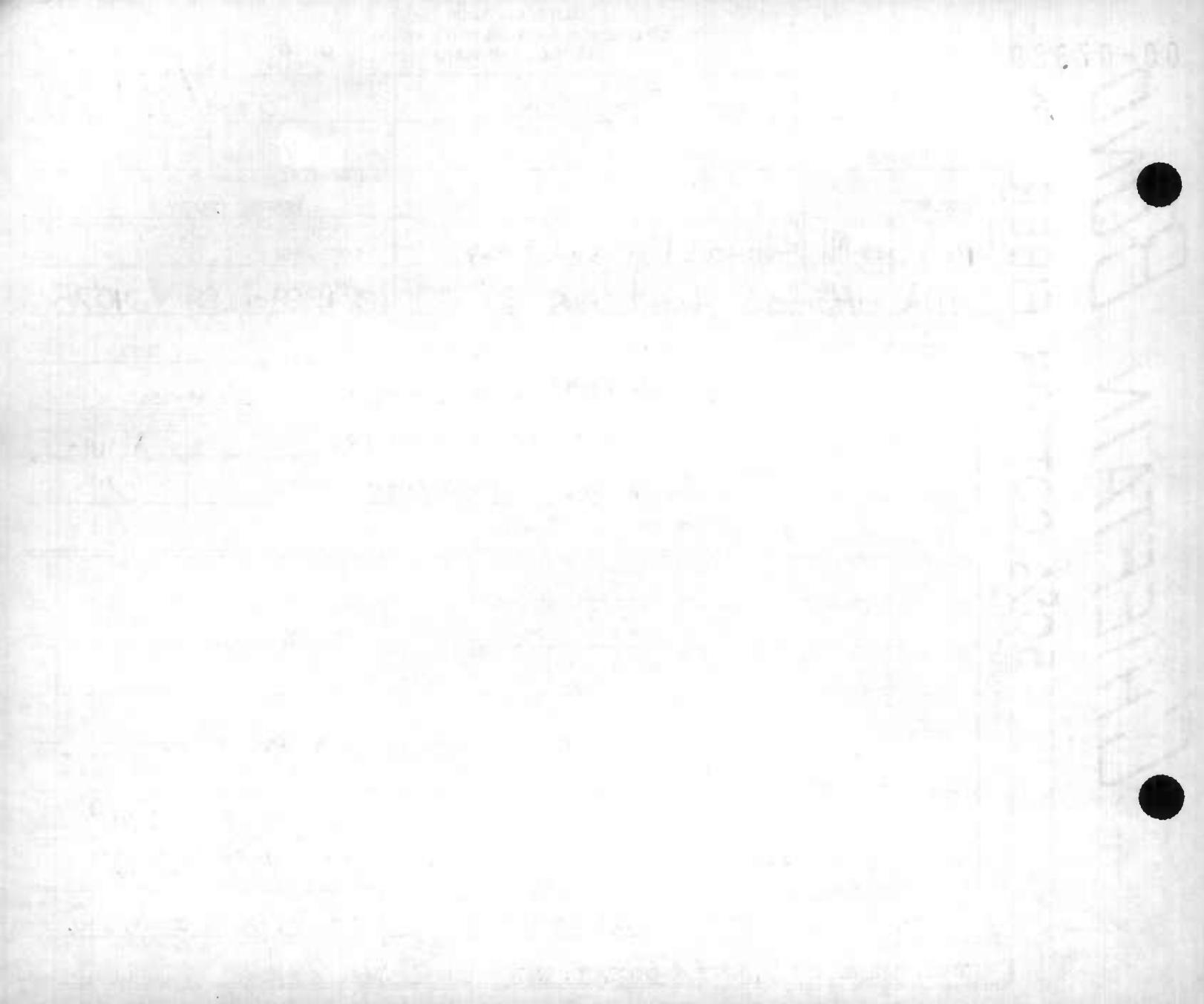
MEDICAL CERTIFICATION

**1 - FOR
STATE
REGISTRATION**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Myrtle DUBREE Ferguson | | | 2a. DATE OF DEATH 5-24-86 | MONTH YEAR | DAY | YEAR | 2b. HOUR 1:30 PM |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH J DAY 5 YEAR 1910 | 6. AGE (IN YEARS AT BIRTHDAY) 75 | 7. IF UNDER 1 YEAR MONTHS 0 | 8. DAYS 0 | 9. IF UNDER 24 HRS HOURS 0 | 10. MINUTES 0 |
| 11. BIRTHPLACE COUNTRY MARYLAND | 12. CITIZEN OF WHAT COUNTRY? USA | 13. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 14. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY | | | | |
| 15. CITY OR TOWN OF DEATH Havre de Grace, MD | | | 16. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp | | 17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 17b. KIND OF BUSINESS OR INDUSTRY |
| 18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 19. STREET ADDRESS / ZIP CODE 608 N. Stokes St / 21078 | | | | |
| 20. STATE MD | 21. COUNTY Harford | 22. CITY OR TOWN Havre de Grace | 23. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 24. STREET ADDRESS / ZIP CODE 608 N. Stokes St / 21078 | | | |
| 25. FATHER'S NAME FIRST THOMAS | MIDDLE | LAST DUBREE | 26. MOTHER'S MAIDEN NAME FIRST FLORENCE | MIDDLE | LAST BOYD | | |
| 27. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 28. SOCIAL SECURITY NO. 21316918Y | 29. INFORMANT CLARENCE A. FERGUSON | 30. ADDRESS SAME AS #13e | | |
| 31. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. | | | 32. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 HRS | | | | |
| (b) MYOCARDIAL | | | 33. DUE TO, OR AS A CONSEQUENCE OF INFARCTION 6 HRS | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 34a. DATE OF OPERATION | 34b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 34a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 34b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 35a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 35b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 35c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) | | | | | |
| 36a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 36b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 36c. LOCATION STREET | CITY OR TOWN | | COUNTY | STATE | |
| 37a. I certify that (I) <input type="checkbox"/> (we) <input type="checkbox"/> hospital attended the deceased from 8-20 , 19 85 , to 5-23 , 19 86 , that (I) <input type="checkbox"/> (we) <input type="checkbox"/> lost soul the deceased alive on 5-24 , 19 86 , and that in (my) <input type="checkbox"/> (our) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death. | | | | | | | |
| 38b. SIGNATURE W. Mithani | 38c. DEGREE MD | | | 38d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 38e. DATE SIGNED 5-24-86 | | |
| 39d. PHYSICIAN'S NAME (TYPE OR PRINT) KAMRUDIN MITHANI | 39e. ADDRESS 131 S. UNION AVE. HAVRE DE GRACE MD 21078 | | | | | | |
| 40a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 40b. DATE 26 MAY 86 | 40c. NAME OF CEMETERY OR CREMATORIAL ROCK RUN CEMETERY | 40d. LOCATION CITY OR TOWN ROCK RUN, HARFORD COUNTY, MD | 40e. COUNTY | 40f. STATE | | |
| 41. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078 | 42. ADDRESS MAY 27 1986 | | | 43. DATE REC'D. BY REGISTRAR MAY 27 1986 | 44. REGISTRAR'S SIGNATURE | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use on the burial permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "No", it is the physician's responsibility to sign any injury or other traumatic event the medical certificate.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 6 1 4 6 2 8 | REG. NO. | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH (MM/DD/YY) | MONTH | DAY | YEAR | 2b HOUR | | |
| Daniel | | | Paul | Fitzpatrick | | 5/8/86 | 5 | -8 | -86 | 6:51 AM | | |
| 3. SEX | | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| MALE | | WHITE | JUNE 9, 1930 | | | 55 | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Haford | | | | |
| Maryland | | U.S.A. | | | | | | MD. | | | | |
| 10. CITY OR TOWN OF DEATH Fallston (21047) | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) President | | |
| 13a. STATE Maryland | | 13b. COUNTY Harford Co. | | 13c. CITY OR TOWN Bel Air | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 325 Choice Street 21014 | | | |
| 14. FATHER'S NAME John | | MIDDLE Thomas | | LAST Fitzpatrick | | 15. MOTHER'S MAIDEN NAME Elizabeth | | | LAST FAHEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 217-22-0309 | | 17. INFORMANT (NAME) 838-5362 ADDRESS MRS. ANN Fitzpatrick 325 Choice Street Bel Air, Maryland 21014 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ascvd</u> | | | | | | | | | | Year | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ascvd</u> | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (SEE ALSO, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. <u>11:15</u> DAY <u>MON</u> YEAR P.M. <u>19</u> | | | 21c. HOW INJURY OCCURRED N/A | | | 21d. NATURE OF INJURY IN ITEM 19 (PART 1 OR PART 2) | | | | |
| 22a. INJURY OCCURRED WHILE <input type="checkbox"/> IN <u>NO</u> AT <u>NO</u> WORK | | 22b. PLACE OF INJURY (AT HOME, STREET, ETC.) <u>NO</u> | | | 22c. LOCATION N/A | | | 22d. CITY OR TOWN | 22e. COUNTY | 22f. STATE | | |
| 22g. I certify that (i) this hospital attended the deceased from <u>5/8/86</u> to <u>5/11/86</u> , that (ii) we last saw the deceased alive on <u>5/8/86</u> at <u>19</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check here) <input type="checkbox"/> | | | | | | | | | | | | |
| 22h. SIGNATURE <u>Dean James</u> | | | | | | | | | | 22i. DEGREE | 22j. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22k. DATE SIGNED <u>5/8/86</u> |
| 22l. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DEAN VASSOR</u> | | 22e. ADDRESS 2003 Rock Spring Rd, Forest Hill, Md. 21050 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>May 10, 1986</u> | | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bel Air Memorial Gardens 50 W. Broadway & Williams St., Bel Air, Maryland 21014 | | | 23d. LOCATION CITY OR TOWN Bel Air, Harford Co., Maryland 21014 | | | 23e. COUNTY Harford | | 23f. STATE Maryland |
| 24. FUNERAL DIRECTOR <u>Joseph William Foster</u> <u>Jewerelle Foster</u> | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 12 1986</u> | | | | | | | | 25b. REGISTRAR'S SIGNATURE <u>Jewerelle Foster</u> | | |
| DHMH - 16 60M 7/84 (VRA 15, 4) | | | | | | | | | | | | |

00-08228

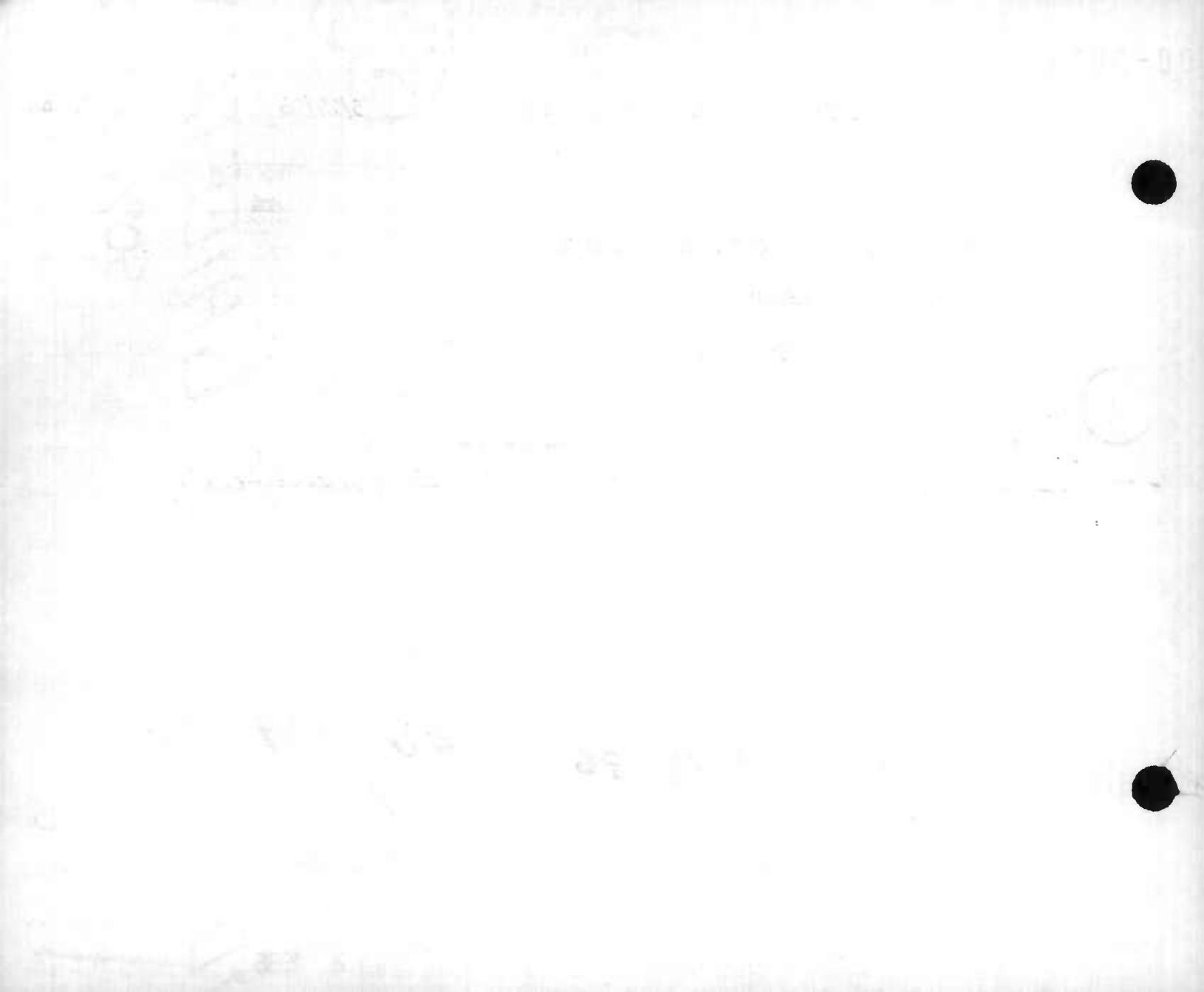
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | 86 14629 | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------|------|----------------------------------|--|
| | | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | |
| LOIS | | | Richmond GLASS | | | 5/29/86 | | | 2 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | |
| Female | | White | | Mar. 14, 1898 | | 88 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD. | | | |
| Maryland | | U.S.A. | | | | Harford | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| HAVRE DE GRACE | | CITIZENS NURSING HOME | | Secretary | | Shipping | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | 206 Angus Drive/21001 | | | | |
| Maryland | HARFORD | Aberdeen | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | |
| George W. Richmond | | | Agnes | | | Lodge | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| NO | | N/A | | 214-12-4588 | | Martha Dreisback, Same as Above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line. If not, list, and include) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| pneumonia | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) COPD resp. insuffis | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 5/29/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | 41 86 to 5/29 86 | | | | | |
| 22b. SIGNATURE JOURNAL TARRING | | | | | | DEGREE TENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) JOURNAL TARRING | | | | | | 22d. ADDRESS 41 86 to 5/29 86 Havre de Grace MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORI | | 23d. LOCATION CITY OR TOWN | | 23e. COUNTY | | 23f. STATE | |
| Burial | | May 30. 1986 | | Oaklawn Cemetery | | Baltimore | | Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE JUN 2 1986 | | | |
| DHMH - 16 50M 4/83 (VRA 15, 4) | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the hospital panel. Then please return carbon copies, Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate panel should be retained by the hospital or attending physician.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8614630 | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|---------|-------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------------------------|-------------------------------------|------------------|-----------------|----------|------|
| | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| JAMES F. GOODMAN | | | | | | May 20, 1986 | | | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | | white | | MONTH August DAY 10, YEAR 1924 | | 61 | | | MONTHS | YEARS | MONTHS | HOURS | MIN. |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | |
| Tennessee | | U.S.A. | | | | | | | Harford County, | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Fallston | | 2521 Forbes Lane | | Ret.- M.T.A. | | | Bus Driver | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| Maryland | | Harford | | Fallston | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2521 Forbes Lane Box 43 21047 | | | | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | FIRST | MIDDLE | LAST | ADDRESS | | | |
| William | | Harvey | Goodman | | Bertha | | Jean | | Singleton | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| Yes | | WW II | | 414 244-28-1406 | | Mrs. Meta M. Goodman | | Same as #13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe T. H. D.</i> | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Joseph Reinhardt</i> | | 22c. DEGREE | | ATTENDING PHYSICIAN | | MEDICAL DIRECTOR | | STAFF PHYSICIAN | | 22d. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Reinhardt, M.D. | | 22e. ADDRESS Fallston General Hospital | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 5-23-86 | | 23c. NAME OF CEMETERY OR CREMATORIAL Westview | | 23d. LOCATION CITY OR TOWN Baltimore, Maryland | | COUNTY | | STATE | | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. | | APPROVED By | | | | 25a. DATE REC'D. BY REGISTRAR MAY 23 1986 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Ruck</i> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours
retained by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having any injury, or other traumatic event, the medical examiner may be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 80 14031 | | | | | | | | | | | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|--------------|-----|-------------------------------------------------------------------------------------------------|---------|-------------------|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|---|---------------------------|--------|------------------------------------------------------------------|--|--|--|---------------------------------------------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME | | | | FIRST | Vernon | MIDDLE | Roy | LAST | Gullion | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 1. DECEASED NAME <u>VERNON</u> | | | | 1. DECEASED NAME <u>ROY</u> | | | | 1. DECEASED NAME <u>GULLION</u> | | | | 5 | 4 | 86 | 304 AM | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | 7. IF UNDER 1 YEAR MONTHS DAYS | | | | 8. IF UNDER 24 HRS HOURS MIN. | | | | | | | | | | | | | | | | | |
| 3. SEX <u>MALE</u> | | 4. RACE <u>WHITE</u> | | 5. DATE OF BIRTH MONTH 9 DAY 30 YEAR 32 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Havre de Grace, Md.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>HARFORD COUNTY</u> | | | | 10. CITY OR TOWN OF DEATH <u>FALLSTON</u> | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <u>FALLSTON GENERAL</u> | | | | 12a. USUAL OCCUPATION <u>Plant Operator</u> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Stone Products</u> | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE | | | | 21040 | | | | | | | | | | | | | | | | | |
| 13a. STATE <u>MARYLAND</u> | | 13b. COUNTY <u>HARFORD</u> | | 13c. CITY OR TOWN <u>EDGWOOD</u> | | | | | | | | 13e. STREET ADDRESS / ZIP CODE <u>3001 Pulaski Hwy. 48</u> | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | | 15. MOTHER'S MAIDEN NAME FIRST | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST <u>Roy</u> | | MIDDLE <u>McCoy</u> | | 15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u> | | | | 16. SOCIAL SECURITY NO. 16b. SOCIAL SECURITY NO. <u>216-28-6954</u> | | | | 17. INFORMANT <u>Mrs. Helen E. Gullion</u> | | | | ADDRESS <u>Edgewood, Md. 21040</u> | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR 1a, 1b, AND 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR 1a, 1b, AND 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a) Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR 1a, 1b, AND 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a) DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Cardiomyopathy</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR 1a, 1b, AND 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a) DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (1) <u>this hospital</u> attended the deceased from <u>5-3</u> 19 <u>86</u> to <u>5-4</u> 19 <u>86</u> , that (1) <u>we</u> last saw the deceased alive on <u>5-4</u> 19 <u>86</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>we</u> <u>did</u> <u>not</u> view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Dr. Vassar Frank A. Hamilton MD</u> | | | | | | | | | | | | 22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Dean L. Vassar MD F.A. Hamilton, M.D.</u> | | | | | | | | | | | | 22e. ADDRESS <u>Fallston Gen. Hospital</u> | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | | | | | | | | | | 23b. DATE <u>May 7, 1986</u> | | 23c. NAME OF CEMETERY OR CREMATORIAL <u>Bel Air Memorial Gardens, Bel Air</u> | | 23d. LOCATION CITY OR TOWN <u>Harford</u> | | 23e. COUNTY <u>Md.</u> | | 23f. STATE | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Howard K. McComas III, Abingdon, Md. 21009</u> | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 6 1986</u> | | 25b. REGISTRAR'S SIGNATURE <u>Frank A. Hamilton</u> | | | | | | | | | | | | | | | | | | | |

71830-00

RECORDED

60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The following physician
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death.

IMPORTANT: If item 21 is marked "X" show any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

14032

| | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST DALLAS | MIDDLE MORGAN | LAST HALL | 2a. DATE OF DEATH MAY 23, 1986 | MONTH DAY YEAR | 2b. HOUR 4:40P M |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR AUGUST 2, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE COUNTRY VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH HAVRE de GRACE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 404 JUNIATA STREET | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) BOILER MECH | | 12b. KIND OF BUSINESS OR INDUSTRY FED GOVT (APG) |
| 13a. STATE MO | | 13b. COUNTY HARFORD | | 13c. CITY OR TOWN HAVRE de GRACE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 404 JUNIATA STREET 21078 |
| 14. FATHER'S NAME FIRST ASA | | | MIDDLE FREBON | | LAST HALL | 15. MOTHER'S MAIDEN NAME FIRST SHRILOA | | MIDDLE LAST BALL |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 579 09 4755 | | | 17. INFORMANT MRS. ERMALEE McCUALEY | | ADDRESS 720 COMMERCE ST HdG, MD 21078 |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Metastatic Sarcoma alone</i></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Histocytic lympho-sarcoma</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) <i></i></p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20 days</i></p> | | | | | | | | |
| <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b.</p> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | COUNTY | STATE |
| <p>22a. I certify that (I) (this hospital) attended the deceased from <i>1984</i>, 19, to <i>05/24/86</i>, that (I) (we) last saw the deceased alive on <i>6/24/86</i>, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p> | | | | | | | | |
| 22b. SIGNATURE <i>Irvin H. Wachman</i> | | DEGREE | | ATTENDING PHYSICIAN | MEDICAL DIRECTOR <input checked="" type="checkbox"/> | STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 24 MAY 86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRVIN WACHMAN, M.D. | | 22e. ADDRESS 407 SOUTH UNION AVENUE, HAVRE de GRACE, MD. 21078 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 28 MAY 86 | | 23c. NAME OF CEMETERY OR CREMATORIAL HARFORD MEMORIAL GARDENS | | 23d. LOCATION CITY OR TOWN ALDINO, HARFORD CO., MO. | | |
| 24 FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078 | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR MAY 28 1986 | | 25b. REGISTRAR'S SIGNATURE <i>Davidson</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certificate should be handled alone.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 80 14033 | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------|--------|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------|-----|------|-------------------------------------------------|--------|-------|
| REG. NO. | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | |
| MINNIE EVELYN Hamby | | | | | | May 16, 1986 | | | | | | 8:30 P.M. | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | |
| FEMALE | | | White | | | MONTH DAY YEAR | | | 92 | | | IF UNDER 24 HRS | | |
| 7a. BIRTHPLACE (STATE, OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MONTHS DAYS HOURS MIN. | | |
| Washington County Virginia | | | U.S.A. | | | May 20, 1893 | | | Harford County | | | MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Abingdon (21009) | | | 312 Amy Drive | | | Postmaster | | | Postal Service | | | 21014 | | |
| 13a. STATE | | | 13b. COUNTY | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE | | | 21014 | | |
| Maryland | | | Harford Co. | | | Bel Air | | | 10 North REED STREET | | | | | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | Flora A. | | | Anderson | | |
| Albert Mitchell Plummer | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT (See) 879-7514 | | | ADDRESS | | | | | |
| NO | | | 216-05-1796 | | | Mr. Gingel L. Hamby | | | 10 North REED STREET | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | IMMEDIATE CAUSE (a) | | | DUE TO, OR AS A CONSEQUENCE OF (b) Decubitus on Coccyx due to an | | | ADDRESS | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) Sclerosis and Senility | | | | | | 47 days | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 5, 1986, to May 16, 1986, that (I) (we) last saw the deceased alive on May 12, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (we) did not view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE Dudley Phillips, M.D. | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | May 18, 1986 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | Office 836-8774, Residence 457-4781 | | | Darlington, Maryland 21034 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE May 19, 1986 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Churchville Presbyterian Cem. | | | 23d. LOCATION CITY OR TOWN | | | CHURCHVILLE, Harford Co., Maryland 21028 | COUNTY | STATE |
| 24. FUNERAL DIRECTOR Joseph William FOSTER | | | 50 W. Broadway & Williams St. ADDRESS Bel Air, Maryland 21014 | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | MAY 20 1986 | | |
| | | | | | | | | | | | | | | |

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Deno # 8,919,254-G-611, 7/3/86

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14634

00-08134

FOR
1- STATE
REGISTRAR
by F.H./M1. DECEASED NAME
(TYPE OR PRINT)

ANNA

FIRST

MIDDLE

LAST

HARTMAN

86

REG. NO.

14634

2a. DATE KNOWN
OF ESTI-
DEATH MATED

MONTH

DAY

YEAR

5 29 86

2b. HOUR

8:40

2c. DATE
PRONOUNCED
DEAD

MONTH

DAY

YEAR

5 29 19

2d. HOUR

8:40

2e. DATE
DEATH MATED

MONTH

DAY

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5 29 19

2d. HOUR

8:40

2f. DATE
DEATH MATED

MONTH

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5 29 19

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2g. DATE
DEATH MATED

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2h. DATE
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2d. HOUR

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2i. DATE
DEATH MATED

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2j. DATE
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2k. DATE
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2q. DATE
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2r. DATE
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DEATH MATED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. They please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 3014035 | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | | | | |
| The Ma Lucille Hoch | | | | | May 28 1986 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 2b. HOUR 6p M | | | |
| Female | | white | | OCTOBER 13, 1917 | | | | | |
| 7a. BIRTHPLACE COUNTRY MISC. | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS | | | |
| 9999 | | USA | | | | IF UNDER 1 YEAR MONTHS DAYS | | | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RECORDS CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY COUNTY GOVT. (CA) | | | |
| 13a. STATE Md. | | 13b. COUNTY Hartford | | 13c. CITY OR TOWN Havre de Grace | | 13e. STREET ADDRESS / ZIP CODE 567 Green St. 21078 | | | |
| 14. FATHER'S NAME FIRST EARL | | MIDDLE J. | LAST BECK | 15. MOTHER'S MAIDEN NAME FIRST LETICE | | LAST JOHNSON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 377-12-1083 | | 17. INFORMANT ERROL B. HOCH | | ADDRESS SAME AS #13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line in Part 1 and Part 2) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) STROKE | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | COUNTY | STATE | |
| 22a. I certify that (1) (the hospital) attended the deceased from 5-14 1986 to 5-28 1986 that (1) (we) last saw the deceased alive on 5-28 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | |
| 22b. SIGNATURE Dante Monakil DEGREE PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL | | | | | | | | 22c. ADDRESS Havre de Grace, MD 21078 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 29 MAY 86 | | 23c. NAME OF CEMETERY OR CREMATORIAL R. A. FERRIS + COMPANY | | 23d. LOCATION CITY OR TOWN WEST CHESTER, | | STATE PA. | |
| 24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078 | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1986 | | 25b. REGISTRAR'S SIGNATURE L. Mitchell | | | | | |
| DHMH - 16 60M 7/B4 (VRA 15, 4) | | | | | | | | | |

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WANTAWA

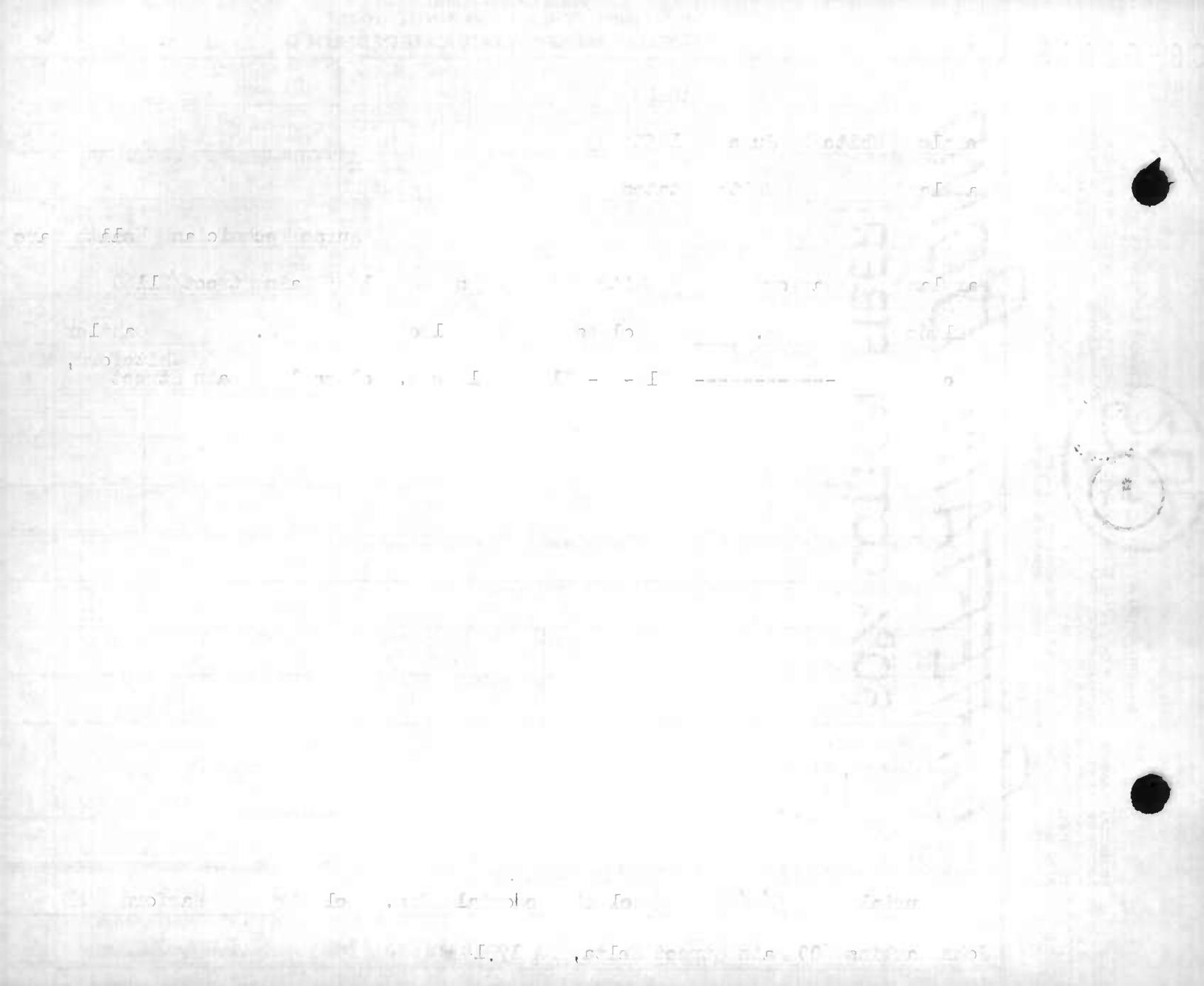
MOTOCYCLES



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED (WITHIN 72 HOURS) AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 101 W. BENTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 14036 | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------|---------------------------|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------|---|------------------------------------------------------------------------------------------------------------------------------------|------|-------|-----|------|----------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE KNOWN EST. DEATH MATED | | MONTH | DAY | YEAR | 2b. HOUR |
| LINDA | | | ADELE | | | HOLMES | | | <input checked="" type="checkbox"/> | | 5 | 3 | 1986 | M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. DATE PRONOUNCED DEAD | 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Female | White | June 6 1952 | 33 yrs. | MONTHS | DAYS | HOURS | FALLSTON | Fallston General Hospital | Nurse Technician | Health Care | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED WIDOWED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Maryland | | United States | | <input checked="" type="checkbox"/> | | Harford County | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Fallston | | Fallston General Hospital | | Nurse Technician | | Health Care | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Whiteford | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1535 Main Street/21160 | | | | | | | | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME FIRST | | MIDDLE | | LAST | | | | | | | |
| Clyde | | A. | | Holmes | | Cleo | | J. | | Cantler | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Clyde A. Holmes 1535 Main Street | | ADDRESS Whiteford, MD | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8189 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) starting the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | | | | | | |
| | | | | | | <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR XXX 5-3-1986 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject exited moving vehicle. | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | | 21f. LOCATION STREET PA Rt. 851 e. of Club House Rd., York, PA CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | |
| ACTUAL SIGNATURE  | | | | | | | | | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | Ann M. Dixon, M.D. | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | DATE SIGNED 5-4-86 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE Burial 5/6/86 | | 23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gdns. | | 23d. LOCATION CITY OR TOWN Bel Air | | COUNTY Harford | | STATE MD | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR MAY 07 1986 | | 25b. REGISTRAR'S SIGNATURE  | | | | | | | | | | | |
| John Harkins | | 600 Main Street Delta, PA 17314 | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please return certificate to Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, given to funeral director, or to any hospital, or other institution, the medical examiner, or other authority.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8614637
REG. NO.

| | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | Frances G. Howell | | | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | |
| 1. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | MONTH | DAY | YEAR | 11 AM | |
| FEMALE | | | WHITE | | | NOVEMBER 13, 1900 | | | | | |
| 7a. BIRTHPLACE COUNTRY | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| GEORGIA | | | USA | | | | | Harford | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Havre de Grace | | | Hartford Mem. Hospital | | | (RET) SELF-EMPLOYED | | | INTERIOT DECORATION | | |
| 13a. STATE | | | 13b. COUNTY | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS / ZIP CODE | | |
| MD | | | HARFORD | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 805 TYDINGS ROAD 21078 | | |
| 14. FATHER'S NAME FIRST | | | MIDDLE | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| JOSEPH | | | PASSE | | | MARTHA | | | LYLES | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| NO | | | 418 16 7195 | | | WILLIAM B. BAXTER | | | SAME AS #13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | | | | |
| Sepsis ASCED DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (c) old age | | | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-20-15-15, 1986, to 5-20-86, 1986, that (I) (we) last saw the deceased alive on 5-20-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| John Yun | | | | | | | | | MAY 20, 1986 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | UNION MEDICAL CLINIC, HAVRE de GRACE, MD 21078 | | | | | |
| JOHN YUN, MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL PEA RIVER PRESBYTERIAN CEM. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| BURIAL | | | 22MAY86 | | | | | | CLIO, BARBOUR COUNTY, ALA. | | |
| 24. FUNERAL DIRECTOR NAME JACKSON-BRYAN FUNERAL HOME, BRUNOIOGE, ALA. MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078 | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| MAY 21 1986 | | | | | | | | | | | |

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Form 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 86 | 14638 | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|------------------------|----------------------------------------------|----------------------------------------------|--|
| | | | | | | | | | | REG. NO. | | | | |
| 1 - FOR STATE REGISTRAR | | 1. DECEASED NAME FIRST ROY | | | | MIDDLE S | | LAST HUGHES | | 2a. DATE OF DEATH MONTH JANUARY | DAY 18, 1986 | YEAR 5 | 2b. HOUR 7:10 P M | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH JANUARY | | | | YEAR 18, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 | IF UNDER 1 YEAR YRS | | IF UNDER 24 HRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY | | | | MD. | | |
| 10. CITY OR TOWN OF DEATH HAVRE DE GRACE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) | | | | 12b. KIND OF BUSINESS OR INDUSTRY UTILITY COMPANY | | | | |
| 13a. STATE MD | | 13b. COUNTY HARFORD | | 13c. CITY OR TOWN HAVRE de GRACE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 627 FOUNTAIN STREET | | 21078 | | | | |
| 14. FATHER'S NAME FIRST STEVENSON | | MIDDLE ARCHER | | LAST HUGHES | | 15. MOTHER'S MAIDEN NAME FIRST MOLLIE | | | | LAST MILLER | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 165 03 0862 | | | | 17 INFORMANT REBECCA M. HUGHES | | | | ADDRESS SAME AS #13e | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF Carcinoma of Prostate | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Arteriosclerotic Heart Dis. | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do not) (do not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED 5-8-86 | | | | |
| 22b. SIGNATURE Leticia S. Galvez | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS 625 S. Union Ave., Havre de Grace, Md. | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10 MAY 86 | | 23c. NAME OF CEMETERY OR CREMATORIAL DARLINGTON CEMETERY | | | | 23d. LOCATION CITY OR TOWN DARLINGTON, HARFORD CO., MD. | | STATE | | | | |
| 24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1986 | | 25b. REGISTRAR'S SIGNATURE John J. Galvez | | |
| DHMH - 16 60M 7/84 (VRA 15, 4) | | | | | | | | | | | | | | |

107 300 12 2

25000000

00-07084

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the doctor be informed within 24 hours after death. Page 4 more be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in the funeral director. Page 1 and 2 should be filled in 24 hours after death. Please forward to the State Dept. of Health and Mental Hygiene prior to burial. (If either, notify medical examiner.)

IMPORTANT: If Item 21 is marked, Item 18 shows any injury, or any traumatic event, the medical examiner should be informed.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 6 3 9
REG. NO.

| | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|---------------------------------------------|------------------|--------------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | ANTHONY J. JESATKO | | 7a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | |
| 1. SEX | | 1. RACE | | 5. DATE OF BIRTH | MONTH | DAY | YEAR | 11:40 | |
| MALE | | CAUCASIAN | | 9 | 17 | | | | |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE | 10b. YEARS LAST BIRTHDAY | | 10c. UNDER 1 YEAR | | |
| MD. | | U.S.A. | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 68 | YRS. | MONTHS | DAYS | 10d. UNDER 24 HRS. |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BEL AIR | | BEL AIR NURSING HOME | | Harford Co, MD | | BETH. STEEL | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | |
| MD. | | HARFORD | | FALLSTON | | CIVIL ENGINEER | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MARRIED NAME FIRST MIDDLE LAST | | 16. STREET ADDRESS / ZIP CODE | | | 17. ADDRESS | | |
| ANTON JESATKO | | CATHERINE KOLARIK | | 1300 MARQUIS CT. 21047 | | | 5400 Deer Park Rd. Owings Mills Md | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 18b. SOCIAL SECURITY NO. | | 17. INFORMANT | | APPROXIMATE AGE BETWEEN CHILD AND DEATH | | | |
| NO | | 219-07-9394 | | CAROL ARROWSMITH (DGHTR) | | 1 year 20 years 20 years 20 years | | | |
| 18. CAUSE OF DEATH: (Enter only one cause per line for 18a, 18b, and 18c.) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) stroke DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE | |
| 22a. I certify that (1) this physician attended the deceased from the deceased alive on 5/16/86 to 5/13/86 and that in my (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) we (I did) (we did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DEGREE | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> | MEDICAL DIRECTOR <input type="checkbox"/> | STAFF PHYSICIAN <input type="checkbox"/> | 22e. DATE SIGNED | |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22g. ADDRESS | | | 22h. ADDRESS | | | 5/16/86 | |
| EMORY LINDER | | 902 AVERILLE Rd, Sopha, MD 20855 | | | 902 AVERILLE Rd, Sopha, MD 20855 | | | 3/20/86 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS | | 23d. LOCATION CITY OR TOWN | COUNTY | STATE | | |
| BURIAL | | 5/19/86 | GARDENS OF FAITH | | BALTIMORE | | | | |
| 24. FUNERAL DIRECTOR (NAME) | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| SCHIMUNEK FUNERAL HOME, INC. 9705 Belair Rd., Balto. Md. 21236 | | MAY 20 1986 | | | Julie Linder | | | | |

8

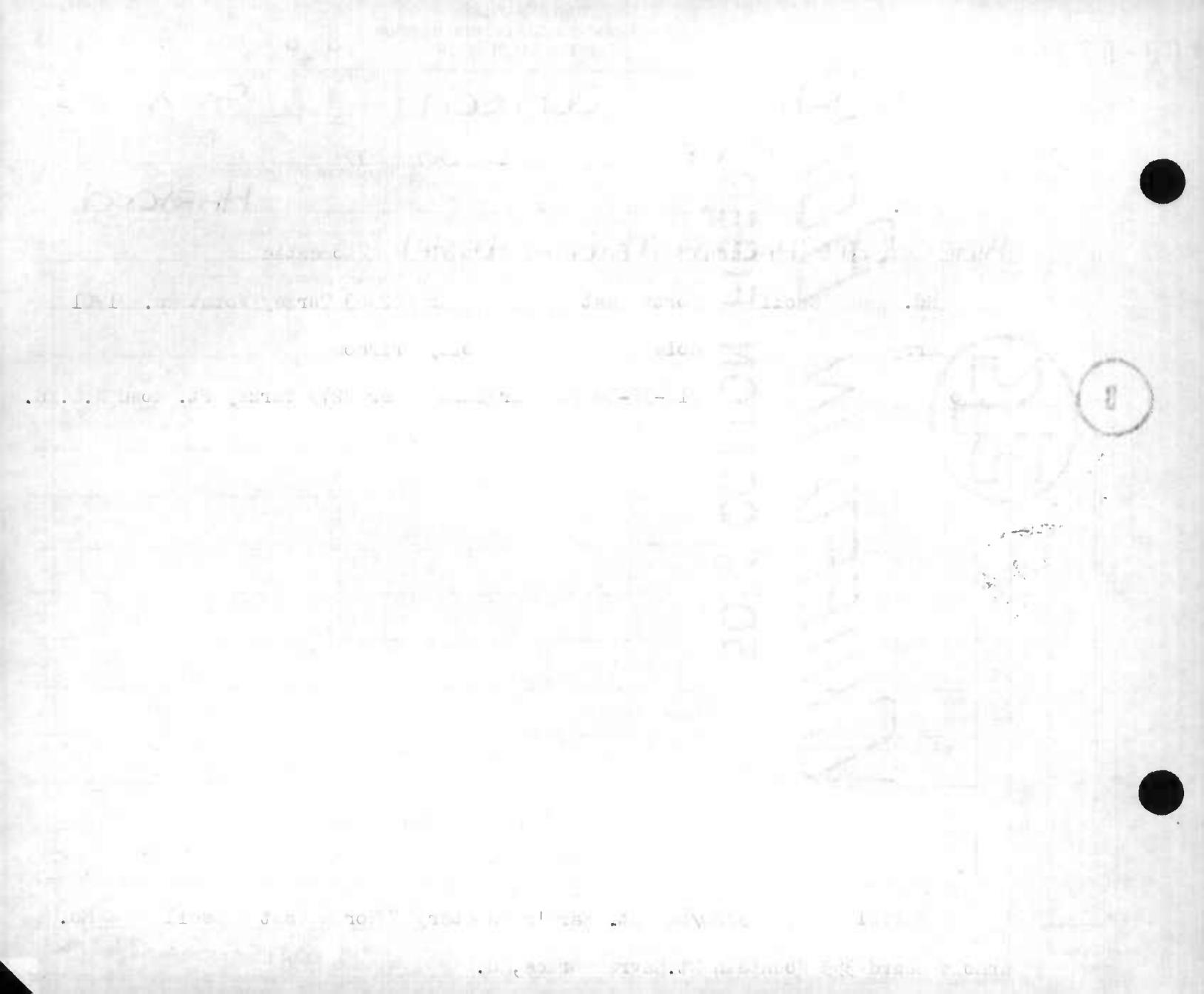
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, the funeral director, page 3 should be retained by the funeral director until 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner may be called in.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 86 14640 REG. NO. | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------|-------|-----|-----------------------------------------------------|----------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| Beulah | | | | | | | | | Johnson | | | 5-16-86 | | | | 10 AM |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | | 8. IF UNDER 24 HRS | |
| FEMALE | | | BLACK | | | MONTH 2 DAY 18 YEAR 1907 | | | 79 YRS | | | MONTHS DAYS | | | HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| Md. | | | USA | | | | | | Harford | | | Domestic | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Havre de Grace | | | Hartford Memorial Hospital | | | | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE | | | 14. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Md. | | | Cecil | | | North East | | | | | | 2583 Turkey Point Rd. 21901 | | | | |
| FATHER'S NAME FIRST | | | MIDDLE | | | LAST | | | 15. MOTHER'S MAIDEN NAME FIRST | | | MIDDLE | | | LAST | |
| Harry | | | | | | Cole | | | Molly Briscoe | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | 18. ADDRESS | | | | | | | |
| No | | | 212-32-3682A | | | Virginia Maker | | | 3279 Turkey Pt. Road N.E. Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bile Peritonitis</u> | | | | | | | | | | | | | | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Blockage Biliary Tract</u> | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Pancreatitis</u> | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/15</u> , 19 <u>86</u> , to <u>9/16</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9/15</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Andrew Nowakowski</u> | | | DEGREE <u>MD</u> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <u>9/16/86</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Andrew Nowakowski MD</u> | | | 22e. ADDRESS <u>125 N. Main St. Bel Air, MD 21014</u> | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE Burial 5/20/86 | | | 23c. NAME OF CEMETERY OR CREMATORIAL St. Mark's Cemetery | | | 23d. LOCATION CITY OR TOWN North East Cecil Md. | | | COUNTY | | | STATE | |
| 24. FUNERAL DIRECTOR NAME <u>Arnold Beard</u> | | | ADDRESS <u>353 Fountain St. Havre De Grace, Md.</u> | | | 25a. DATE REC'D. BY REGISTRAR MAY 22 1986 | | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | | | | | | | |
| BP | | | | | | | | | | | | | | | | |
| DHMH - 16 60M 7/84 (VRA 15, 4) | | | | | | | | | | | | | | | | |



00-05179

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, be retained by the hospital or attending physician.

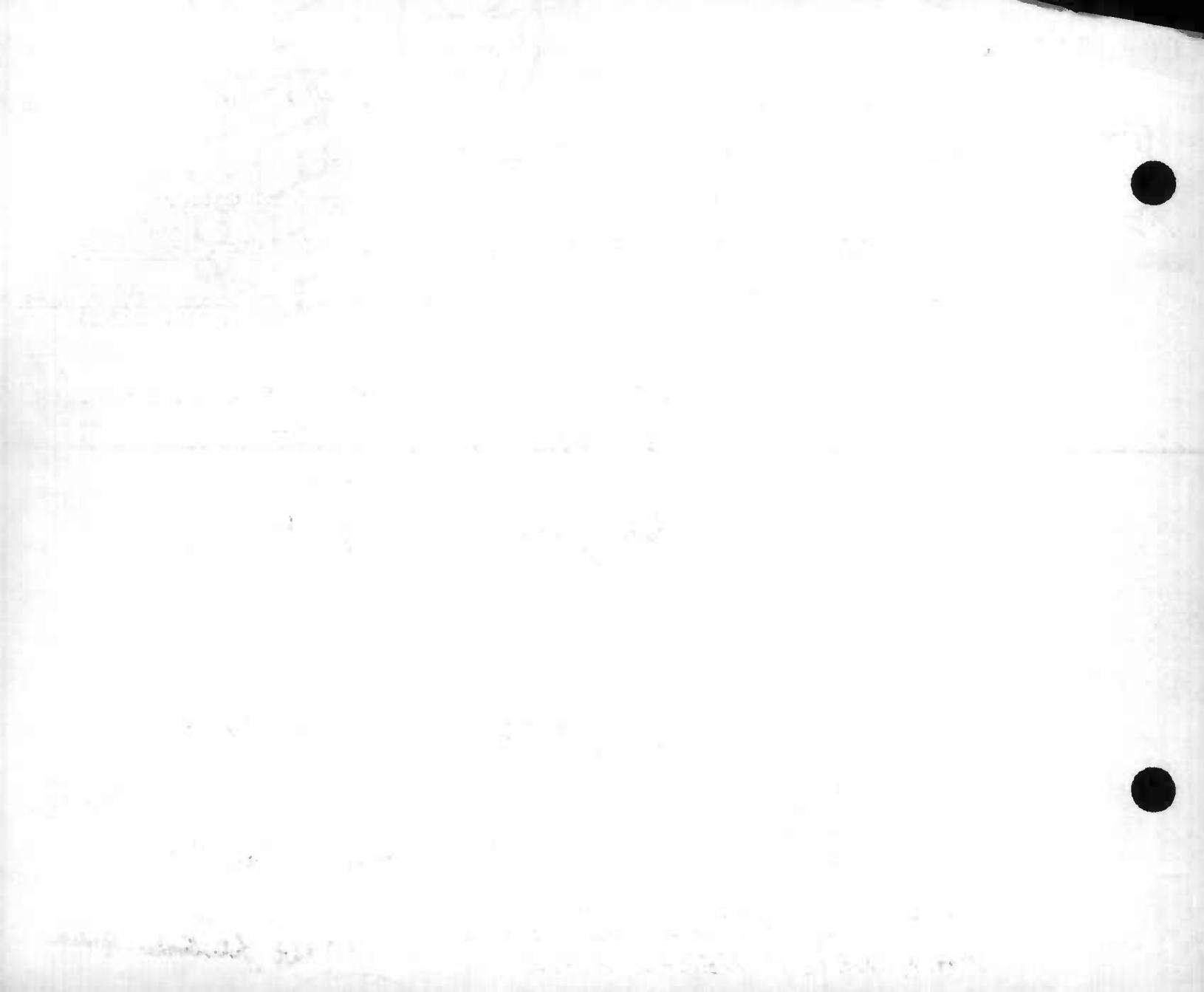
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the Burial-Transit permit. Then leave removable carbon adhesives. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 is shown any injury, or other traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8614641
REG. NO.

| | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|-------|---------------------------------------------------------------------------------------|------|-------------------------------------------------------------------------------------------------|-------|----------------------------------------------------------------|--------|-----------------|-------|------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | | |
| Robert W. Kahler | | | | | | 4/27/86 | | | | 11:45am | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | | Cauc. | | MONTH | DAY | YEAR | 56 | YRS | MONTHS | DAYS | HOURS | MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD. | | |
| Md. | | USA | | | | | | Harford County | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Forest Hill | | 1404 Persimmon Place | | Machine Opr. | | Western Electric | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13e. STREET ADDRESS / ZIP CODE | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Forest Hill | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1404 Persimmon Pl. Forest | | Hill, Md. 21015 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| Jacob Kahler | | | | | | Barbara E. Plasik | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 16c. INFORMANT | | ADDRESS | | | | | | |
| YES | | Korean 217-24-6483 | | Carmela Kahler, wife, same address | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio pulmonary Arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>General Deliritation</i> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Emphysema</i> <i>Allergy</i> | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that (1) (the hospital) attended the deceased from 4/25/86 to 4/27/86, 19, to present, that (1) (we) last saw the deceased alive on 4/25/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) not see the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED 4/27/86 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | |
| R Smith | | Palloton Ben. Hesp | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE 4/30/86 | | 23c. NAME OF CEMETERY OR CREMATORIAL Gardens of Faith | | 23d. LOCATION CITY OR TOWN Balto., Md. | | COUNTY | | STATE | | |
| Burial | | 9705 BELAIR RD. - 21236 | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME | | | | | | 25a. DATE REC'D. BY REGISTRAR APR 30 1986 | | 25b. REGISTRAR'S SIGNATURE John L. Schimunek | | | | |



00-05823

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 REG. NO.

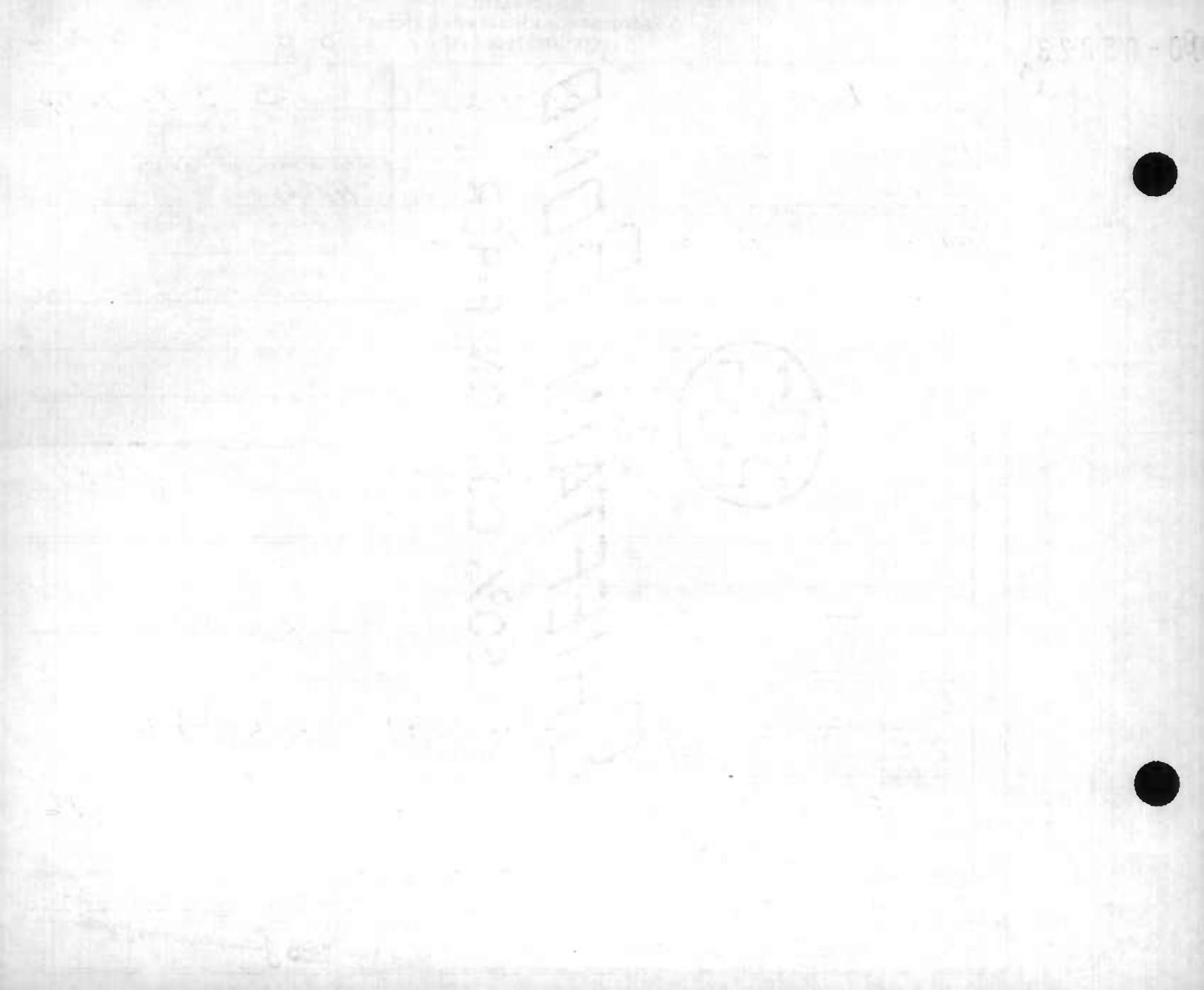
1 4 6 4 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

| | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | |
| <i>DORA</i> | | | | <i>Kostick</i> | 5 | 3 | 86 | 12:15pm | | |
| 3. SEX: | | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| <i>Female</i> | | <i>White</i> | MONTH Dec. | DAY 7 | YEAR 1902 | 83 | YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| <i>Kent, England</i> | | <i>USA</i> | | | <i>Harford</i> | MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| <i>Fallston</i> | | <i>Fallston General Hospital</i> | | | <i>Housewife</i> | | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | |
| <i>md.</i> | | <i>Harford</i> | <i>Belair</i> | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> | <i>711 Country Village Dr. 21014</i> | | | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | FIRST | MIDDLE | LAST | |
| <i>William</i> | | | | <i>Sullivan</i> | <i>Louise</i> | | | | <i>Webb</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | ADDRESS | | | |
| no | | <i>213-74-3632</i> | | | <i>Kathleen Corcoran</i> | | <i>5 Glenwood Road 21014</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CHF</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>yes</i> |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Auto of Skewers</i> | | | | | | | | | | <i>years</i> |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | <i>years</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.c | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | 21g. CITY OR TOWN | 21h. COUNTY | 21i. STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1978</i> to <i>1981</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Dean L. Van</i> | | 22c. DEGREE <i>MD</i> | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. DATE SIGNED <i>5-3-86</i> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>WASSER</i> | | 22e. ADDRESS | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE <i>5/6/86</i> | | 23c. NAME OF CEMETERY OR CREMATORIAL <i>Gardens of Faith</i> | | 23d. LOCATION CITY OR TOWN <i>Rossville</i> | | 23e. COUNTY <i>Baltimore</i> | 23f. STATE <i>Maryland</i> | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 6 1986</i> | | 25b. REGISTRATION NO. <i>JL 2442</i> | | | | | | |
| <i>Connelly Funeral Home 300 Mace Ave. 21221</i> | | | | | | | | | | |



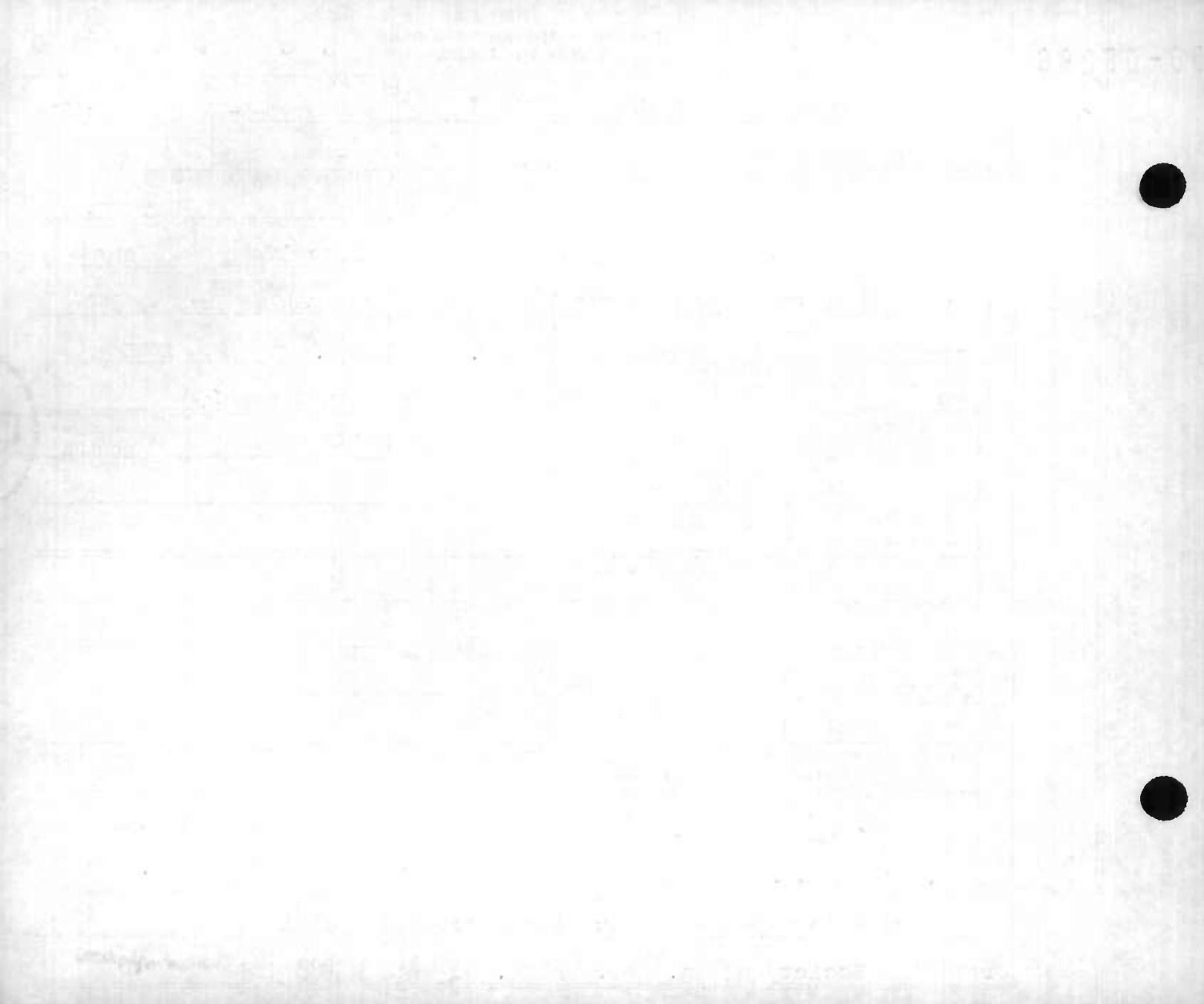
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and initially filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8614643 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--|
| 1 - STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-5-86 | | | | | | | 2b. HOUR 6:45 P.M. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 10. DATE OF BIRTH MONTH DAY YEAR 10-4-07 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS | | |
| LALITA HARILAL KOTHARI | | | | | | | | | | | |
| 3. SEX FEMALE | | | 4. RACE H | | | 5. DATE OF BIRTH MONTH DAY YEAR 10-4-07 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS | | |
| | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MORVI - GUJRAT | | | 7b. CITIZEN OF WHAT COUNTRY? INDIA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD, MD. | | |
| 10. CITY OR TOWN OF DEATH HAVRE DE GRACE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HARFORD MEMORIAL HOSPITAL | | | 12a. USUAL OCCUPATION Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY HARFORD | | | 13c. CITY OR TOWN CHURCHVILLE | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST BHOGILAL | | | MIDDLE MODI | | | 15. MOTHER'S MAIDEN NAME FIRST M. B. MIDDLE MODI | | | 13e. STREET ADDRESS / ZIP CODE 140 Goucher way 21028 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 437-57-6072 | | | 17. INFORMANT Barry Parekh Same as #13 | | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HERPES SIMPLEX ENCEPHALITIS WITH COMA | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months | |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-31, 1986, to 5-5, 1986, that (I) (we) last saw the deceased alive on 5-5, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED 5-5-86 | |
| 22b. SIGNATURE B. Parekh, M.D. | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH, M.D. | | | 22e. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 05-07-86 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Security Process | | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY STATE Md. | | |
| 24. FUNERAL DIRECTOR NAME Cremation Society of Md. Inc. Balto. Md. | | | 25a. DATE REC'D. BY REGISTRAR MAY 9 1986 | | | 25b. REGISTRAR'S SIGNATURE Julie Davidson-Parekh | | | | | |
| | | | | | | | | | | | |



10-05607

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 14644 | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------|------------------------------------------------------------|-----------------------|--|--------------------------------------|--------|--|------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE KNOWN OF ESTI- MATED | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| Richard | | | | | | PALMER | | | KRAUSS | | | 5 2 1986 | | | 4:30 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | MONTH DAY YEAR | | | 2d. HOUR | | |
| M | | W | | 12 6 33 | | 52 yrs. | | MONTHS DAYS | | HOURS MIN. | | 5 2 1986 | | | 5:30 AM | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | NEVER MARRIED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Port de Sa | | | USA | | | <input checked="" type="checkbox"/> | | | <input type="checkbox"/> | | | HARFORD | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Havre de Grace | | | HARFORD Memorial | | | | | | | | | | | | Lawyer | | | - | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | 21028 | | | | | | | |
| MD | | | HARFORD | | Chesapeake | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 3307 CO 001 Branch Rd | | | | | | | | | | |
| 14. FATHER'S NAME FIRST | | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME FIRST | | | MIDDLE | | | LAST | | | | | | | |
| JOHN | | | CLAUDE | | KRAUSS SIR. | | VELMA | | | | | | PALMER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | | | | | | | |
| No | | | 213-30-6400 | | | Hospital Record | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF ASCVD - Hypertension - Diabetes | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | | | STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | |
| ACTUAL SIGNATURE Luis E. Reijer | | | TITLE (SPECIFY) M.D. Deputy | | | | | | | | | | | | MEDICAL EXAMINER | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Luis E. Reijer | | | ADDRESS 464 Alliance St. Havre de Grace | | | | | | | | | | | | DATE SIGNED 5-2-86 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE 5 May 1986 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Baker Cemetery | | | 23d. LOCATION CITY OR TOWN ABERDEEN HARFORD MARYLAND | | | COUNTY | | | STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR MAY 5 1986 | | | 25b. REGISTRAR'S SIGNATURE Julia Reijer | | | | | | | | | | | |
| TARRING FUNERAL HOME, P.A., ABERDEEN, MD, 21001-3349 | | | | | | | | | | | | | | | | | | | | |

200 CDR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial transit permit. Then please remove carbon copy of death certificate. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification must be completed.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 0 1 4 6 4 5 | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|------------|----------------------------------------------------|------------------------------------------------------------|
| | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST GUY | MIDDLE LAFAYETTE | LAST LACKEY | 2a. DATE OF DEATH | | | MONTH 5/ | DAY 20 | YEAR 86 | 2b. HOUR 1:15A M | |
| 3. SEX MALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH MONTH March DAY 22 YEAR 1897 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cherryville, N.C. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD | | | MD. | |
| 10. CITY OR TOWN OF DEATH Harve De Grace | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supr. Motor Pool | | | 12b. KIND OF BUSINESS OR INDUSTRY US-govt. Ret. | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Harford | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 903 Edgewood Road 21040 | | | | |
| 14. FATHER'S NAME FIRST Olbert | | | MIDDLE Ferree | | | 15. MOTHER'S MAIDEN NAME FIRST Beuna | | | MIDDLE Vista | | | LAST Whitworth | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. WWI | | | 17. INFORMANT William H. Bangledorf, 901 Edgewood Road | | | ADDRESS Edgewood, Md. 21040 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardiovascular disease</i> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Old atherosclerotic wall myocardial infarction</i> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Benign Prostatic</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED 5/21/86 | | | |
| 22b. SIGNATURE <i>Howard K. McComas III</i> | | | | | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22c. ADDRESS 308 S. Union Ave. Harve De Grace, Md. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE May 22, 1986 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Trinity Lutheran Cemetery, Joppa | | | 23d. LOCATION CITY OR TOWN Harford | | | COUNTY Md. | |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 21 1986 | | | 25b. REGISTRAR'S SIGNATURE <i>Howard K. McComas III</i> |



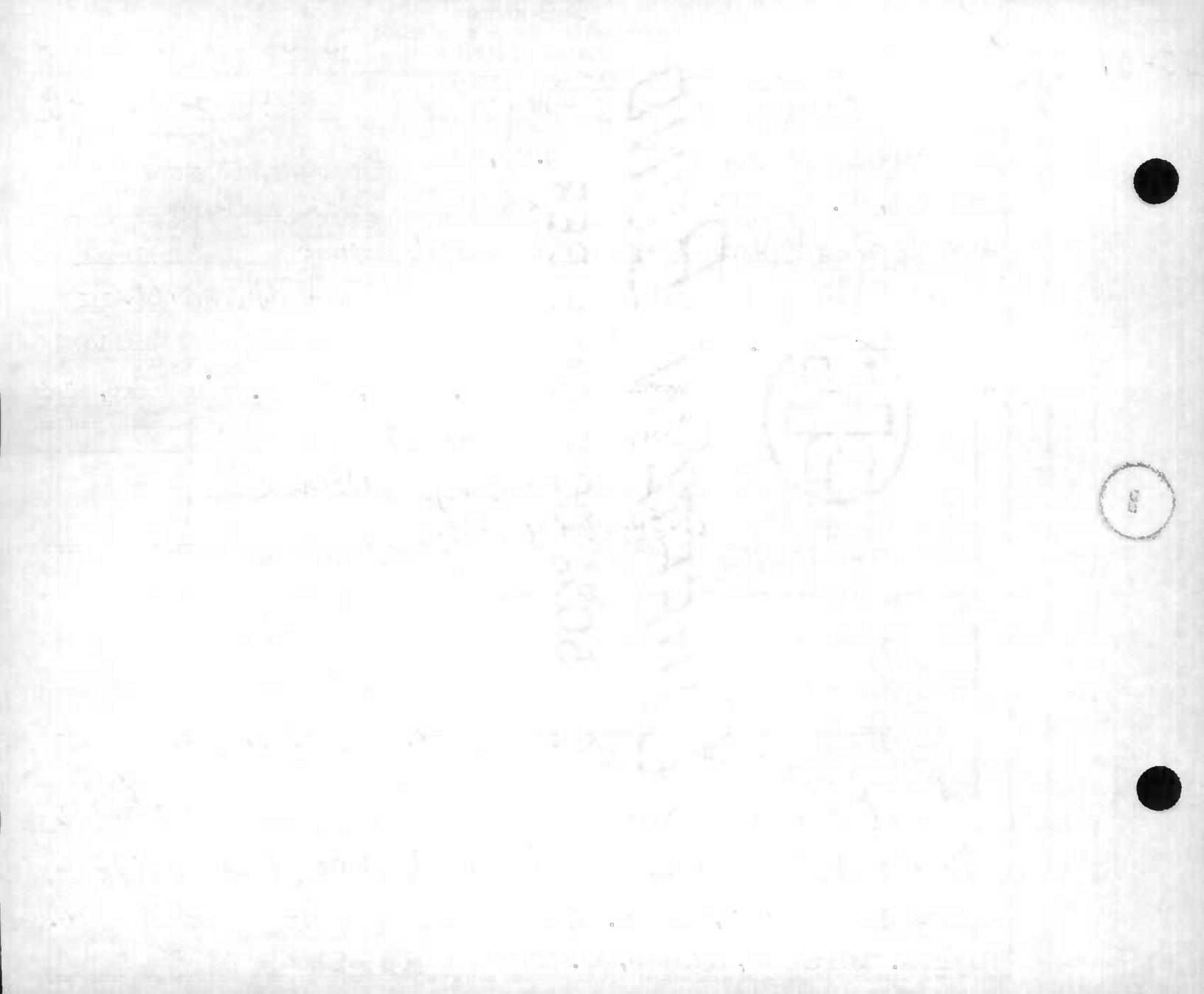
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director. Page 3 should be detached from the hospital or attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 86 14046 | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| 1 - STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR May 24, 1986 | | | | | | | | | 2b. HOUR 13 7 PM | | |
| 1 DECEASED NAME (TYPE OR PRINT) Charles Charles W. | | | MIDDLE James Willard | | | Lilley | | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 23, 1899 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 3. SEX Male | | | 4. RACE white | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North East, Md. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | | |
| 10. CITY OR TOWN OF DEATH Harve de Grace | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer | | | 12b. KIND OF BUSINESS OR INDUSTRY Railroad | | |
| 13a. STATE Md. | | | 13b. COUNTY Harford | | | 13c. CITY OR TOWN Bel Air | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 1504 Westview Ct. 21014 | | |
| 14. FATHER'S NAME FIRST Charles MIDDLE Richard LAST Lilley | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Virginia LAST Keithley | | | | | | ADDRESS Md. 21014 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. -- | | | 17. INFORMANT | | | | | | | | |
| | | | 717-07-6002 | | | James W. Lilley, 1506 Westview Court, BelAir | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Arteriosclerosis | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-15, 1986, to 5-24, 1986, that (I) (we) last saw the deceased alive on 5-24, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | 22b. DATE SIGNED 5/24/86 | | |
| 22c. SIGNATURE DANTE MONAKIL | | | | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL | | | 22e. ADDRESS Harve de Grace, Md 21028 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE May 27, 1986 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Mr. Zion Cemetery | | | 23d. LOCATION CITY OR TOWN Bel Air | | | COUNTY Harford | STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009 | | | 25a. DATE REC'D. BY REGISTRAR MAY 28, 1986 | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| BP _____ | | | | | | | | | | | | | | |
| DHMH - 16 60M 7/B4 (VRA 15, 4) | | | | | | | | | | | | | | |



00-08449

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the certificate and given to the funeral director. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury or other traumatic event, the medical certificate should be detached from the death certificate and filed with the State Dept. of Health and Mental Hygiene.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 8614641 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|------------------|
| 1- STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR 5-30-86 | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Frederick</i> | | FIRST: <i>Frederick</i> | | MIDDLE: <i></i> | | LAST: <i>Lohrmann</i> | | 2b. HOUR 9:25 P.M. | | | | |
| 3. SEX Male MALE | | 4. RACE Cau. WHITE | | 5. DATE OF BIRTH MONTH 5 DAY 41919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | 2b. HOUR IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | | |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co., MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Fallston | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General | | 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe Fitter | | 12b. KIND OF BUSINESS OR INDUSTRY Ship Build | | | | |
| 12c. STATE Md. | | 12d. COUNTY Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 139 N. Curley St. 21224 | | | | | | |
| 14. FATHER'S NAME FIRST: Robert | | MIDDLE: Lohrmann | | 15. MOTHER'S MAIDEN NAME FIRST: Minnie | | MIDDLE: | | LAST: Buenke | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO 213-05-5446 | | 17. INFORMANT | | ADDRESS | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>an 11th floor fall from 13th floor</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Seconds | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) <i>long standing heart disease</i> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. 19 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/4/86 to 5/28/86, 1986, to 5/30/86, 1986, that (I) (we) lost sow, the deceased alive on above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <i>B. MacDonald</i> | | 22c. DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED 4/2/86 | | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>B. MacDonald</i> | | 22f. ADDRESS 9 S. Highland Ave | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY: Burial | | 23b. DATE 6/3/86 | | 23c. NAME OF CEMETERY OR CREMATORIALake View Cem. | | 23d. LOCATION CITY OR TOWN | | 23e. COUNTY | | 23f. STATE Md. | | |
| 24. FUNERAL DIRECTOR NAME <i>B. Dabrowski & Son</i> | | ADDRESS 2818 E. Baltimore St. | | 25a. DATE REC'D. BY REGISTRAR JUN 4 1986 | | 25b. REGISTRAR'S SIGNATURE <i>B. Dabrowski</i> | | | | | | |
| D.M.H.M. - 16 60M 7/84 (VRA 15, 4) | | | | | | | | | | | | |

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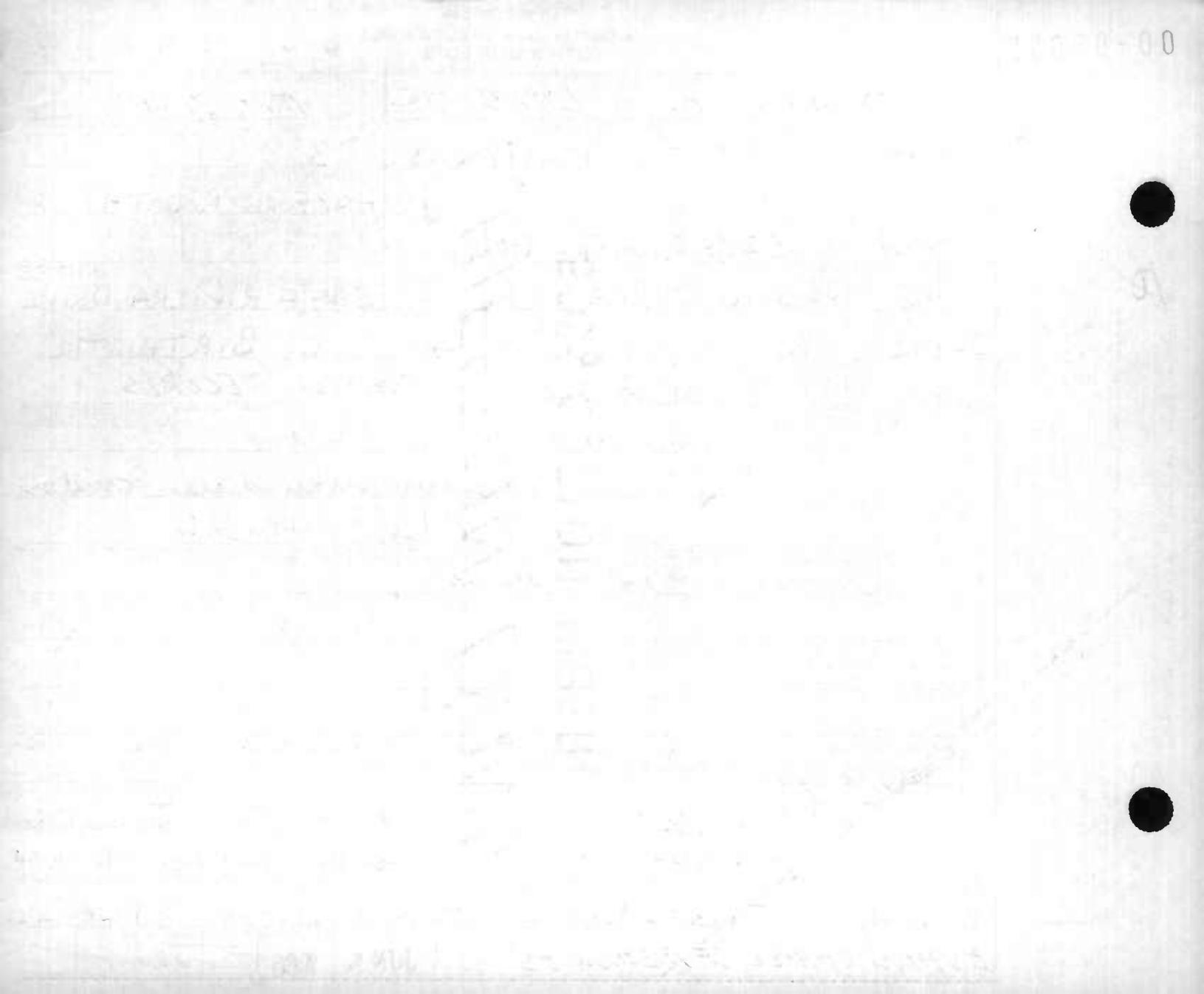
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or consulted.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 8614048 | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--|----------|--------------------------------|--|--------------------------------|-------------------------------------------------|--|--|
| | | | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | | | | |
| JAMES B. LYONS JR. | | | | | | MAY 31 1986 | | | M | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | |
| MALE | | WHITE | | MAY 7 1913 | | | 73 | | | YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| MARYLAND | | U. S. A. | | | | | HARFORD COUNTY | | | MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| JOPPA | | 524A RIVIERA DRIVE | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE | | 21085 | | | |
| MD. | | HARFORD | | JOPPA | | | | | | 524A RIVIERA DRIVE | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | | | |
| JAMES B. LYONS, SR. | | MARY C. BIRTHSTILE | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| No | | 213103812 | | | | | FAMILY RECORDS | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for item (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Cardio-pulmonary Failure. | | | | | | | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF (b) Severe Coronary artery disease Several yrs. | | | | | | | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus, Hypertension | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | | | | | | | | | |
| | | Chronic Renal Failure | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-9-1986 to 4-8-1986, that (I) (we) last saw the deceased alive on 4-8-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | | | | | | | 22c. DATE SIGNED | | | |
| ASHOK NARANG, MD | | | | | | | | | | | | June 2, 1986 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | |
| ASHOK NARANG, MD | | 1131 Bel Air Rd., Bel Air MD 21014 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | | COUNTY | | STATE | | | |
| BURIAL | | June 3 1986 | | LORRAINE PARK | | | BALT. MORE | | | MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR EVANS CHAPEL OF MEMORIES | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | | | | | | | JUN 5 1986 June Sanderson, Jr. | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, TRANSIT LIBRARY, "TRANSPORTER" OR "TRANSPORT" DIVISION OF THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

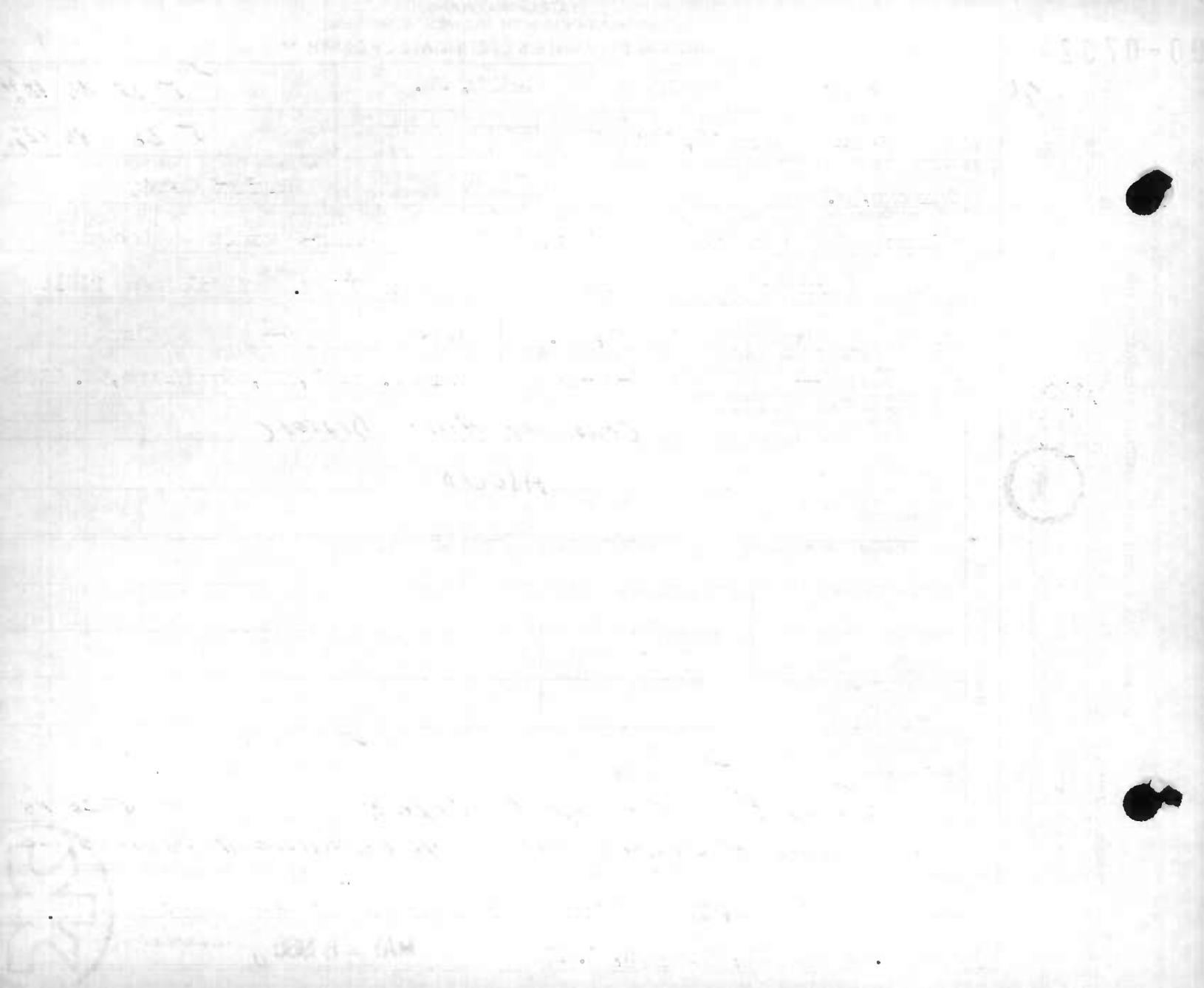
MEDICAL CERTIFICATION

1-
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

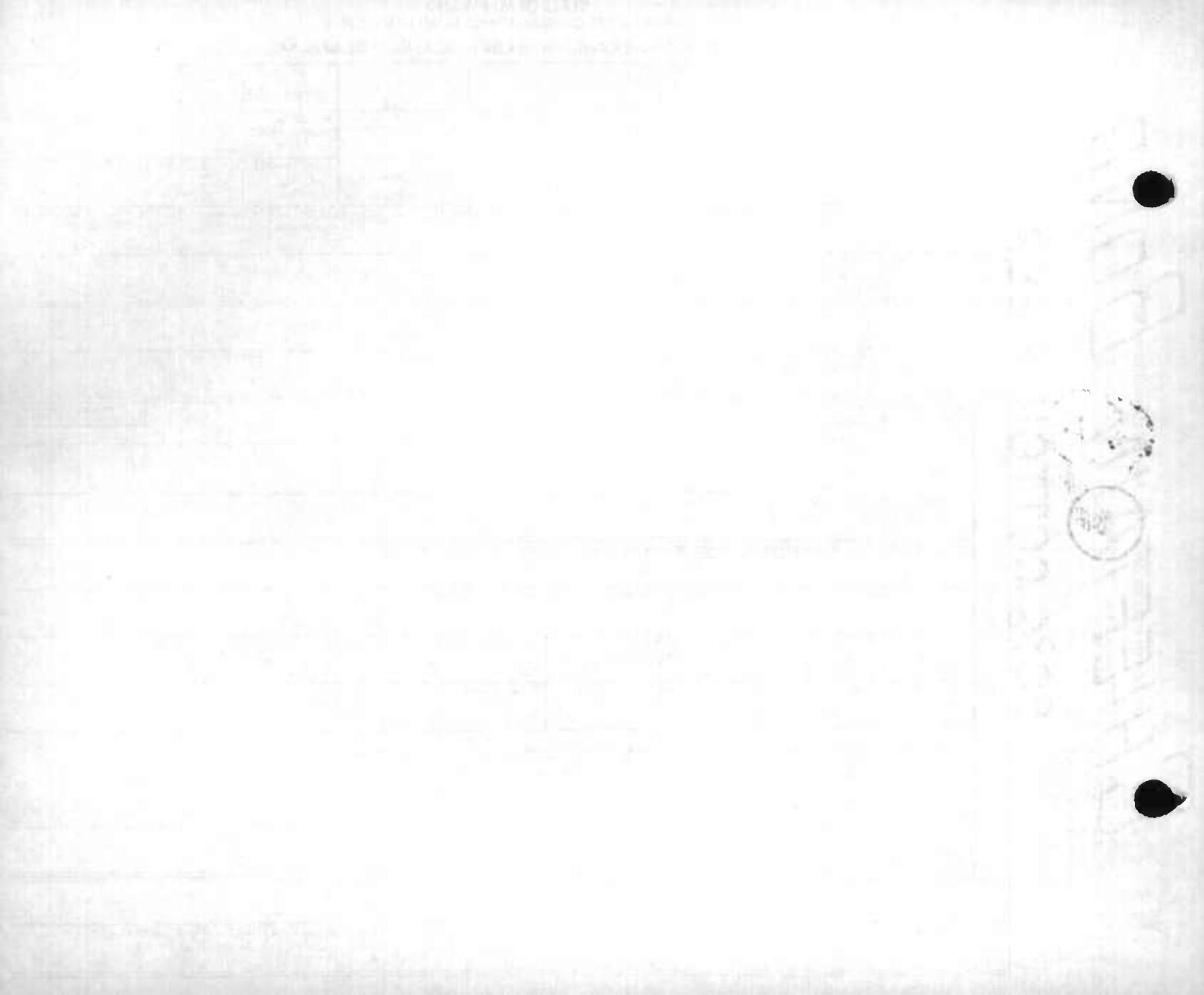
REG. NO. 4649

| | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------|---------|----------------|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF ESTI- DEATH MATED | MONTH | DAY | YEAR | 2b. HOUR | |
| STEWART | | | GARCIA | MANUEL, JR. | <input type="checkbox"/> | 5 | 25 | 86 | 10 AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | 7. IF UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD | MONTH | DAY | YEAR | 2d. HOUR | |
| Male | White | June 12, 1928 | 57 | | | 5 | 26 | 19 | 86 | 12 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Baltimore, Md. | | USA | | | | | Harford County | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Fallston | | Fallston General Hospital | | | Owner-Operator | | Hobbyist | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | |
| Maryland | Harford | Bel Air | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 711 W. MacPhail Road | | 21014 | | | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | | MIDDLE | LAST | | | | |
| Stewart | | Garcia | Manuel, Sr. | Lois | | — | Clark | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | 215-22-4938 | | Stewart G. Manuel, III, Joppatowne, Md. | | 21085 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <i>ASCD</i> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Luis E. Renfro</i> | | TITLE (SPECIFY) M.D. <i>Deputy</i> | | | MEDICAL EXAMINER | | DATE SIGNED | | <i>5-26-86</i> | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | <i>Luis E. Renfro M.D.</i> | | | ADDRESS <i>4649 Orleans St. Havre de Grace</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | 23d. LOCATION CITY OR TOWN | | COUNTY | STATE | | |
| Burial | | May 29, 1986 | | Bel Air Memorial Gardens | | Bel Air | | Harford | Md. | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Howard K. McComas III, Abingdon, Md. 21009 | | | | MAY 28 1986 | | <i>Jane Davidson-Kendall</i> | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 4650 | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|------------------------------------------------------------------------------------------------------------|------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|------------------------------------|--|---------------------------------------------------------------------|-------------------|-----------------------|----------------------------------------------------------------------------------------------|--|--------------------------------|-------------------------------------------------|--|----------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE KNOWN OF ESTI- DEATH MATED | | | 2b. HOUR | | |
| MARK J. MC MENAMAN | | | | | | | | | | | | <input checked="" type="checkbox"/> 5-18-86 19 | | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| Male | | White | | Jan. 5 1961 | | | 25 yrs. | | | MONTH DAYS | | HOURS MIN | | 5-18-86 19 | | | 3:45a |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED WIDOWED | | | NEVER MARRIED DIVORCED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | |
| New Jersey | | | U.S.A. | | | | | | | | | Harford County | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Conowingo | | | Rt. 1 and Conowingo Dam | | | | | | | | | Employee | | | Osbourne Boat Sales | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | |
| Maryland | | | Harford Co. | | | Belair | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 610 S. Main St.-21014 | | | | | | |
| 14. FATHER'S NAME FIRST | | | MIDDLE | | | LAST | | | 15. MOTHER'S MAIDEN NAME FIRST | | | LAST | | | | | |
| Joseph | | | | | | McMenaman | | | Patricia | | | Shannan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | | | | |
| | | | 156-58-0675 | | | Joseph McMenaman | | | 728 Princeton Ave. | | | Bricktown NJ. 08724 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8150 IMMEDIATE CAUSE (a) Neck and head injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of a truck/fixed object impact | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy. | | | 21f. LOCATION STREET Rt. 1 and Conowingo Dam harford Co., Md. | | | CITY OR TOWN | | | COUNTY | | STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Margarita Korell</u> M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | | | | TITLE (SPECIFY) | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | | | | | | DATE SIGNED 5-18-86 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | | COUNTY | | STATE | | | |
| Burial | | | 5/21/86 | | | St. Catherine's Cem. | | | Monmouth | | | New Jersey | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 21231 | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Lilly & Zeiler, Inc. | | | 19011 Eastern Ave. | | | | | | MAY 19 1986 | | | | | | | | |
| DHMH - 17 (VR A15 ME (S)) | | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered to the funeral director or mortician. Then give a copy to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as "Yes", then any injury or other traumatic event, or medical condition that occurred before death, should be reported on the death certificate.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

80 14651

| | | | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------|-----------|---------------------|------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | |
| ARTHUR A. McMULLEN | | | | | | 5 | 16 | 86 | 5:38 P.M. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS. | |
| Male | | White | | July 12, 1932 | | 53 YRS. | | MONTHS | DAYS | HOURS | MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD. | | | |
| Maryland | | USA | | | | Harford | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Harford de Grace | | Harford Memorial Hospital | | Constr. worker | | Kimball Constr. Co. | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Maryland | | Cecil | | Port Deposit | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 848 Principio Rd. | | 21904 | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | LAST | | |
| Joseph | | | Allen | McMullen | Mary | | Louise | | Alexander | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | 218-28-5498 | | Ruth A. McMullen | | 848 Principio Rd. 21904 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <u>ACUTE INFECT-POSTEMOR MI</u> BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u></u> minutes (c) <u></u> hours. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18a. | | | | | | | | | | | |
| 19a. MEDICAL CERTIFICATION | | 19b. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-16-86</u> to <u>5-16-86</u> , that (I) (we) last saw the deceased alive on <u>5-16-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Barry A. Wohl</u> | | 22c. DEGREE MD | | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22e. DATE SIGNED <u>5-16-86</u> | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Barry A. Wohl</u> | | 22f. ADDRESS <u>2003 Rocksprin Rd.</u> | | 22g. LOCATION CITY OR TOWN <u>Forest Hill</u> COUNTY <u>MD</u> STATE | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE May 19 1986 | | 23c. NAME OF CEMETERY OR CREMATORIAL Hopewell Cemetery | | 23d. LOCATION CITY OR TOWN <u>Port Deposit</u> COUNTY <u>Cecil</u> STATE <u>Maryland</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Lee A. Patterson</u> | | 25a. ADDRESS <u>Lee A. Patterson & Son Perryville, Maryland</u> | | 25b. DATE REC'D. BY REGISTRAR <u>MAY 20 1986</u> | | 25c. REGISTRAR'S SIGNATURE <u>John F. Fidler, Esquire</u> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked there is any injury, or other traumatic event, the medical examiner should be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 8 6 1 4 6 5 2 | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|-------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------|-----------------------------------------------------------------------------------------------------------------------------------------------|--|-------|-------------------------------------------------|----------|-------------------|------------------------|-----|-------|----------|
| REG. NO. | | | | | | | | | | | 2b. HOUR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| Chase Kellam Mears | | | CHASE | | | Kellam | | | MEARS | | | 5 | 23 | 86 | 10:15 | A M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | | 8. IF UNDER 24 HRS | | | |
| Male | | White | | MONTH 3 DAY 08 YEAR 1901 | | | 85 | | | YRS | | | MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | | | |
| Virginia | | U.S.A. | | | | | Harford County, | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Joppa Town | | 953 Rumsey Place 21085 | | Pharmacist | | | Retail Drugs | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE | | | | | | |
| Maryland | | Harford | | Joppa Town | | | | | | 953 Rumsey Place 21085 | | | | | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | | LAST | | | 15. MOTHER'S MAIDEN NAME FIRST | | | MIDDLE | | | LAST | | | |
| Charles | | | | Mears | | | Margorie | | | | | | Kellam | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | 18. ADDRESS | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| Yes | | WW I | | 212.07.8492A | | | Suzanne M. Merritt Joppa, MD 21085 | | | | | | | | | |
| 18. CAUSE OF DEATH: (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC POORLY DIFFERENTIATED ADENOCARCINOMA</u> | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | | | STATE | | | |
| 22a. I certify that (I) (we) attended the deceased from <u>10/22/86</u> to <u>10/23/86</u> , that (I) (we) last saw the deceased alive on <u>10/22/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (we) did not view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATOR | | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | 5/23/86 | | | |
| John P. Edwards | | 2112 BALTIMORE ROAD | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | | 23e. COUNTY | | | 23f. STATE | | | |
| Cremation | | 5/24/1986 | | Green Mount Cemetery | | | Baltimore City, MD | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Walter Brooks Bradley, Inc. Balto., MD 21222 | | | | | | | | | | | | | | | | |

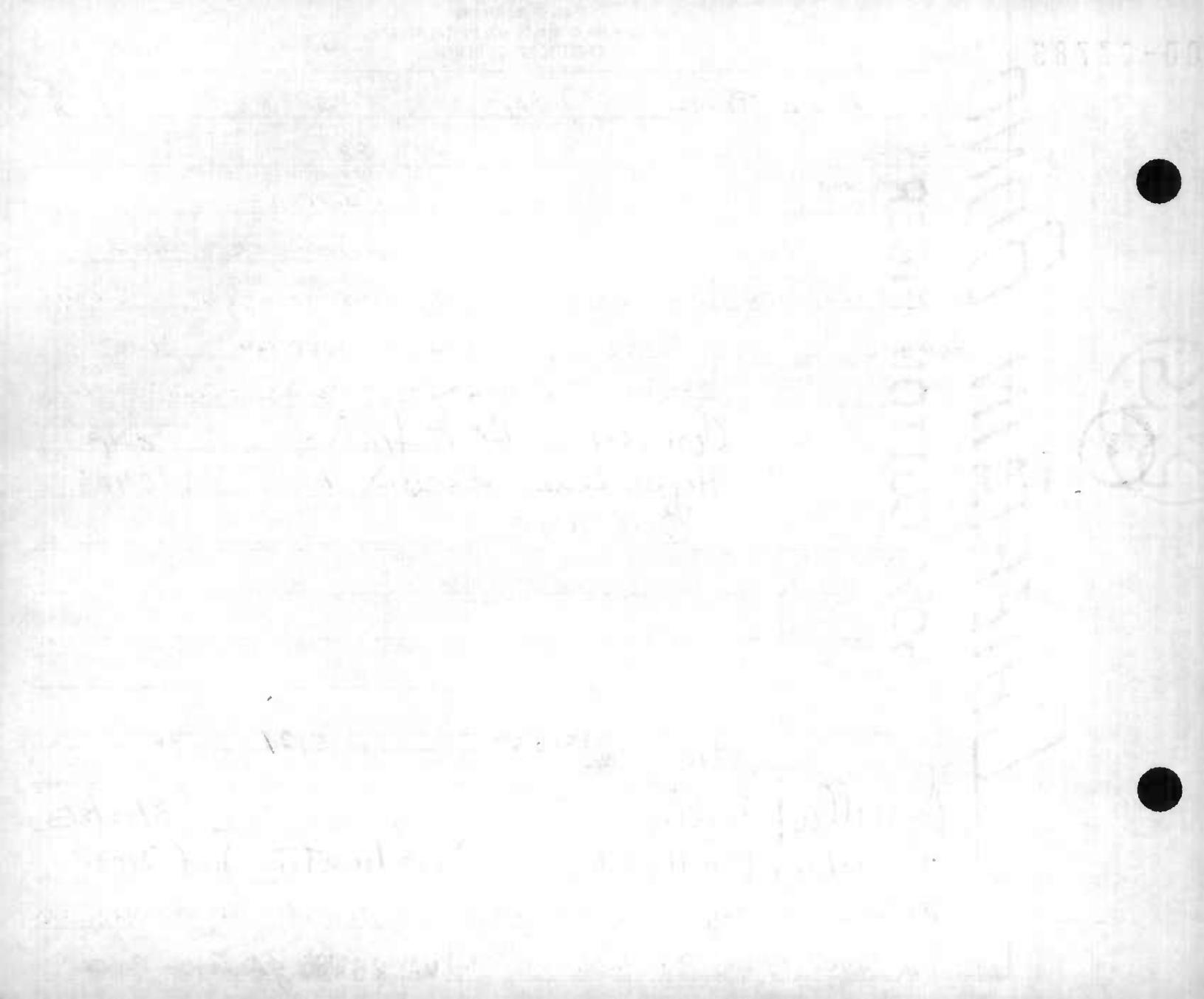
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove this paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as above, only injury or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 86 14653 | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------|-------|-----|-----------------------------------------------------------------------------------------------------------|----------|--|------------------------------------------------------------------|--|--|-----------------------------------|--|--|
| REG. NO. | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | | | | | | | |
| NINA PEARL MORRIS | | | | | | | | | | | | 5-21-86 | | | | 8:45 AM | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | | 8. IF UNDER 24 HRS | | | | | | | | |
| FEMALE | | | WHITE | | | MONTH DAY YEAR | | | 88 | | | MONTHS DAYS | | | HOURS MIN. | | | | | | | | |
| 7a. BIRTHPLACE COUNTRY | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Harford Co. | | | U.S.A. | | | | | | Harford | | | | | | Harford Md. Brevin 739. Home | | | HOMEMAKER | | | HOME | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE | | | 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| MARYLAND | | | Harford | | | DARLINGTON | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 1645 POOLE ROAD 21034 | | | FIRST | | | MIDDLE | | | LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | 18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| NO | | | 216-40-6873 | | | JOANNA SIEBERT, 840 GILBERT ROAD ABERDEEN, MD | | | | | | Congestive Heart Failure | | | | | | | | | 21001 | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hyper Tension ASCVD + | | | DUE TO, OR AS A CONSEQUENCE OF (c) Old age | | | | | | | | | | | | | | | | | | 5 days | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | | 10415 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | | | STATE | | | | | | | | |
| 22a. I certify that (I) (we) attended the deceased from 11:51 65, 19 86, to 5:24 1, 19 86, that (I) (we) last saw the deceased alive on 5/10 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | | | | | | | | | | | |
| Dudley Phillips | | | | | | | | | | | | | | | | | | 5/22/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | |
| Dudley Phillips MD | | | Darlington Md 21034 | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | | CITY OR TOWN | | | COUNTY | | | STATE | | | | | |
| BURIAL | | | 23 May 1986 | | | BEL AIR MEM. GARDENS | | | BEL AIR | | | BEL AIR | | | HARFORD | | | MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | |
| TARRING FUNERAL HOME, P.A. | | | 21001-3899 | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | MAY 26 1986 | | |



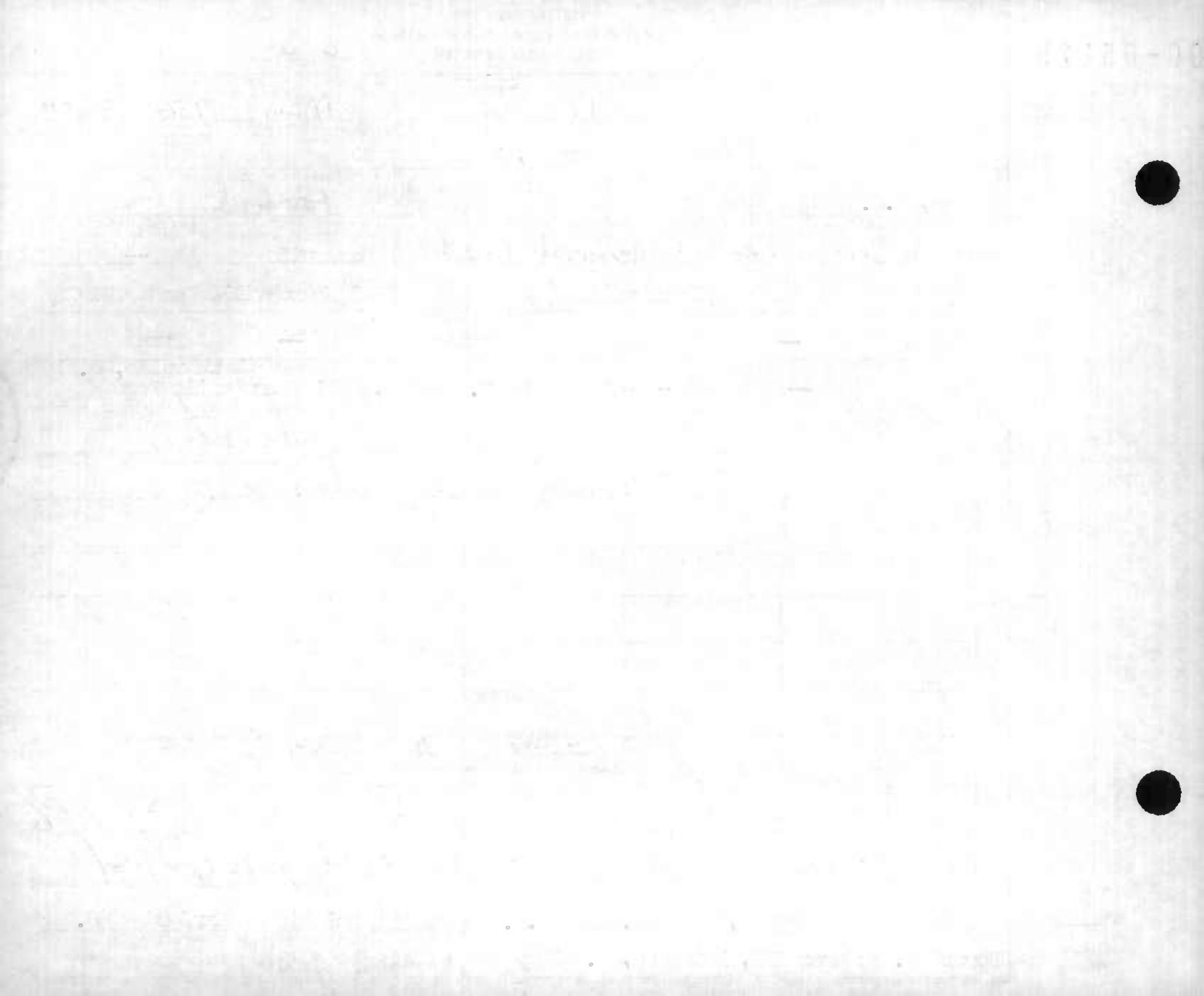
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as shown any injury, or other traumatic event, the medical examiner must be notified and informed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8614654 REG. NO. | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|---------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------|--------|----------------|-------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | Pressie | MIDDLE | Reid | LAST | Moxley | 20. DATE OF DEATH | MONTH | DAY | YEAR | 21. HOUR | |
| <i>Pressie R.</i> | | | | | | | <i>Moxley</i> | <i>May 1, 1986</i> | | | | | <i>9:05 AM</i> | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | | | |
| Female | | White | | Month June 8, 1904 Year | | | 81 | | MONTHS | | DAYS | | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | |
| Sparta, N.C. | | USA | | | | | <i>Harford</i> | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| <i>House de Grace</i> | | <i>Harford Memorial Hospital</i> | | <i>Housewife</i> | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | 14. STREET ADDRESS / ZIP CODE | | | | | |
| Maryland | | Harford | | Churchville | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2821 Churchville Road | | | 21028 | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | 16. ADDRESS | | | | | | |
| | | Isaac | — | Edwards | Bettie | | | Churchville, Md. 21028 | | | Evans | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| NO | | 218-72-3195 | | Guy R. Moxley, 2821 Churchville Road | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for Part 1 and Part 2) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | | | | | |
| <i>Acute myocardial infarction</i> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease</i> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION STREET | | CITY OR TOWN | | | COUNTY | | STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-18</i> , 19 <i>86</i> , to <i>5-1</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>5-1</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DEGREE | | | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. DATE SIGNED | | | | | |
| <i>John D. Gruber</i> | | | | | | | <i></i> | | <i>5/1/86</i> | | | | | |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22g. ADDRESS | | | | | <i>Hanale Grace Md</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | 23e. COUNTY | | | STATE | | |
| Burial | | May 3, 1986 | | Mt. Zion U.M. Cemetery | | | Bel Air | | Harford | | | Md. | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Howard K. McComas III, Abingdon, Md. 21009 | | | | | | | MAY 2 1986 | | <i>Jane Davidson</i> | | | | | |



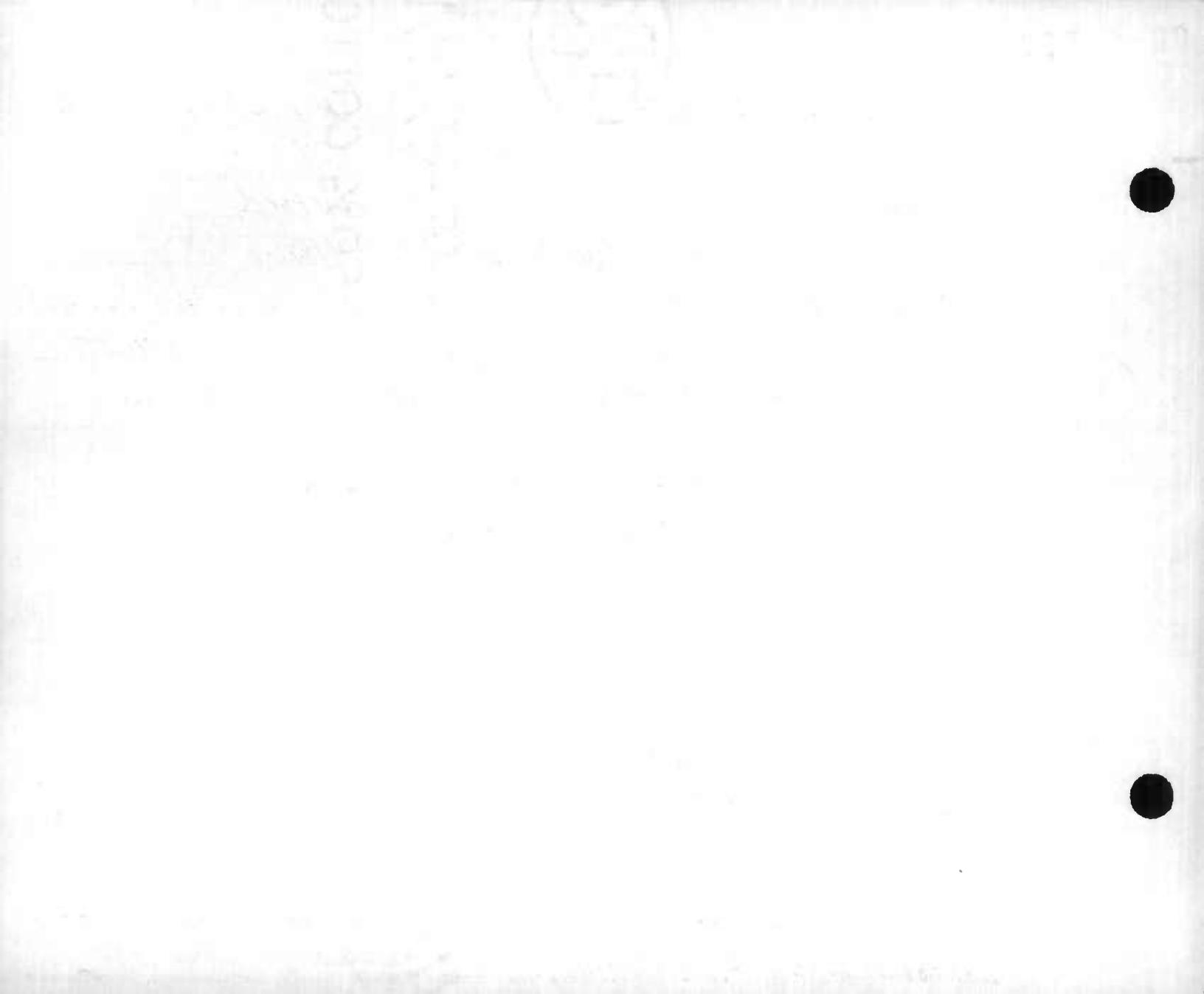
00-08592
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 2 and 2A should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed at once.)

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 86 14655 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 20. DATE OF DEATH MONTH DAY YEAR | | | 20b. HOUR | | |
| Ella Wilkens Myers | | | | | | May 27, 1986 | | | 3:15 PM | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH SEP. DAY 27 YEAR 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford | | | MD. | | |
| 10. CITY OR TOWN OF DEATH Grace | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Churchville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS/ ZIP CODE 2902 Rolling Green Dr. / 21028 | | |
| 14. FATHER'S NAME FIRST Wilbur MIDDLE S. LAST Wilkens | | 15. MOTHER'S MAIDEN NAME KABER | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT MARIAN L. POTTEN, Same As Above | | ADDRESS | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR IS CONSEQUENCE OF (b) MYOCARDIAL INFARCTION | | | | | | | | | | | |
| DUE TO, OR IS CONSEQUENCE OF (c) ARTERIOSCLEROSIS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-27-86 to 5-29-86, that (I) (we) last saw the deceased alive on 5-27-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Dante N. Monakil MD | | | | | | | | | | | |
| 22c. DEGREE | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE N. MONAKIL | | 22e. ADDRESS House of Grace, Md 21078 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/cremation | | 23b. DATE 5/27/86 | | 23c. NAME OF CEMETERY OR CREMATORIAL R.A. Ferris & Co. | | 23d. LOCATION CITY OR TOWN West Chester, Chester, PA | | 23e. COUNTY | | | |
| 24. FUNERAL DIRECTOR NAME TAKING Funeral Home, PA, ADDRESS TAKING Funeral Home, PA, Aberdeen MD, 21001-3392 | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE John Davidson, Registrar | | | | | | | | | |



00-07051

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8614056
REG. NO.1- STATE
REGISTRAR

| | | | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST <i>Helen</i> | MIDDLE <i>M</i> | LAST <i>Olivera</i> | 2a. DATE OF DEATH <i>May 17 1986</i> | MONTH YEAR | DAY | YEAR | 2b. HOUR <i>1:05 PM</i> | |
| 3. SEX Female | | 4. RACE White | 5. DATE OF BIRTH MONTH Jan. | | | DAY 23 | YEAR 1915 | 6. AGE IN YEARS LAST BIRTHDAY 71 | | IF UNDER 1 YEAR MONTHS YRS. | IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE COUNTRY <i>Hawaii</i> | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Hartford</i> | | | |
| 10. CITY OR TOWN OF DEATH <i>Havre de Grace</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hartford Mem Hospital</i> | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | | | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Cecil</i> | | 13c. CITY OR TOWN <i>Port Deposit</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <i>P.O. Box 12</i> 21904 | | | |
| 14. FATHER'S NAME FIRST <i>Iszum</i> | | MIDDLE ----- | LAST <i>Medeiros</i> | 15. MOTHER'S MAIDEN NAME FIRST <i>Agnes</i> | | | MIDDLE ----- | LAST <i>Teixeira</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. ----- | | | 17. INFORMANT Shirley A. Fraley | | | ADDRESS Lot 21 Cochranville Trailer Park, Cochranville | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIOPULMONARY ARREST</i> | | | | | | | | | | | APPROXIMATE NUMBER OF HOURS BETWEEN ONSET AND DEATH 19:30 |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hepatic Coma</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>CIRRHOSIS</i> | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-17 86</i> to <i>5-17 86</i> , that (I) (we) last saw the deceased alive on <i>5-17 86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Andrew Nowakowski MD</i> | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATED SIGNED <i>5/17/86</i> | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ANDREW NOWAKOWSKI MD</i> | | 22f. ADDRESS <i>125 N. MAIN ST. BLDG AIR, MD</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 20, 1986 | | 23c. NAME OF CEMETERY OR CREMATORIAL Mt. Erin Cem. | | | 23d. LOCATION CITY OR TOWN Havre de Grace | | COUNTY | STATE MD. | |
| 24. MEDICAL DIRECTOR NAME Lee A. Patterson & Son, Perryville, Maryland | | 25a. DATE REC'D. BY REGISTRAR MAY 20 1986 | | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendle</i> | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that in death or suicide be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 may be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "No", 8 shows any injury- or other traumatic event, no medical examiner will be called.

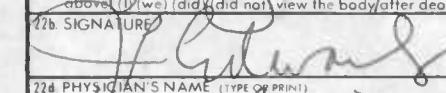
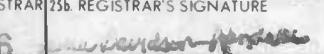
BP

12030-00

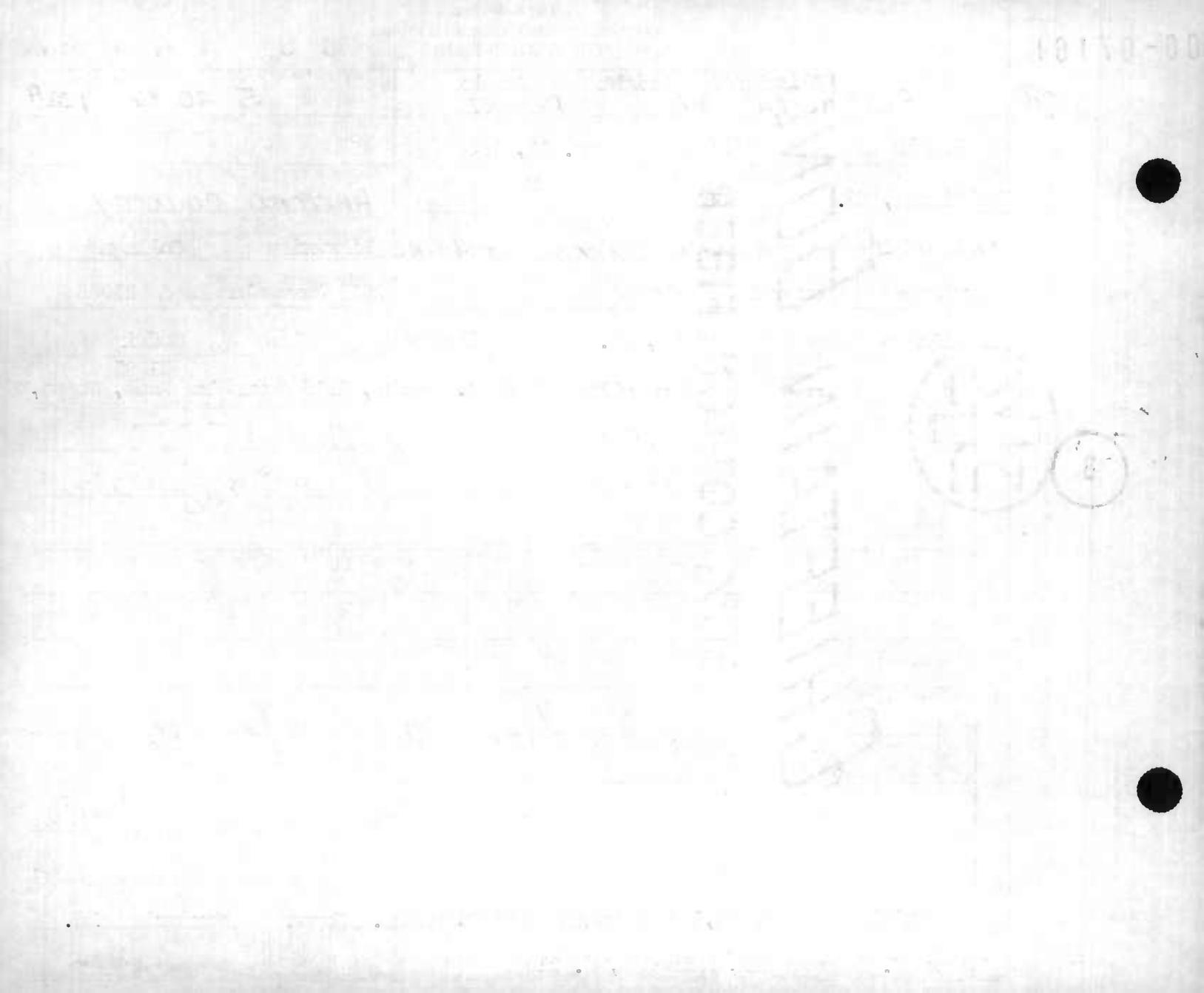


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please send the same to the State Dept. of Health and Mental Hygiene prior to a burial, cremation or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------|----------------|----------------------------------------------------------------|--|
| 8 0 1 4 6 5 7 REG. NO. | | | | | | | | | | | |
| 1 - STATE REGISTRAR | 1. DECEASED NAME (TYPE OR PRINT) | FIRST Elizabeth MIDDLE Wright LAST Penski | | | 2a DATE OF DEATH | MONTH | DAY | YEAR | 2b HOUR | | |
| | | ELIZABETH W PENSKI | | | | | | | 5 20 86 130 AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | MONTH Aug. DAY 12, 1940 YEAR | | 45 | | MONTHS DAYS | | HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Baltimore, Md. | | USA | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | HARFORD COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | |
| FALLSTON | | FALLSTON GENERAL HOSPITAL | | | | | | | | | |
| 12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a STATE | | 13b COUNTY | | 13c. CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS / ZIP CODE | | | |
| Maryland | | Harford | | Joppa | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2515 Jerusalem Road | | 21085 | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST Philemon | | Kennard | | Wright, Jr. | | FIRST Elizabeth | | MIDDLE Glen LAST Coffin | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | | | | |
| no | | -- | | 215-38-1199 | | Elwin C. Penski, 2515 Jerusalem Road, Joppa, Md. | | 21085 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) RETROGRADE SARCOMA OF UTERUS - METASTATIC 5 years | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (we) attended the deceased from 5/19/86 to 5/20/86, that (I) (we) last saw the deceased alive on 5/19/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE  DEGREE MD | | | | | | | | | | | |
| 22c. DATE SIGNED 5/20/86 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. ADDRESS 2112 BELAIR RD FALSTON HARFORD MD 21085 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 24, 1986 | | 23c. NAME OF CEMETERY OR CREMATORIAL Mountain Christian Cem. | | 23d. LOCATION CITY OR TOWN Joppa | | COUNTY | | STATE | |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009 | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR MAY 21 1986 | | 25b. REGISTRAR'S SIGNATURE  | | | | | |

10110-00



00-08507

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO. 4058

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, SERVING WITH FORM WA. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED (WITHIN 72 HOURS) AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|--|-------------------------------------------------------|--|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------|--|-----------------------------------------------------------|--|
| 1- STATE REGISTRAR | | 2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH 5 DAY 20 YEAR 1986 | | | | | | 2b. HOUR 11:40 M | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Andrew Wallace | | | LAST Potter | | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? United States | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County | | | | |
| 3. SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR April 12 1986 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. 1 | | IF UNDER 1 YR. 1 MONTHS 8 DAYS | | IF UNDER 24 HRS. 0 HOURS 0 MIN | | 10. CITY OR TOWN OF DEATH Havre de Grace | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Cardiff | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1584 Main Street/21024 | | 14. FATHER'S NAME FIRST Jeffrey MIDDLE A. LAST Potter | | 15. MOTHER'S MAIDEN NAME FIRST Luianne | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Jeffrey A. Potter 1584 Main St. Cardiff, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autops <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | | | DATE SIGNED May 21, 86 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE Burial May 23, 1986 | | 23c. NAME OF CEMETERY OR CREMATORIAL Slate Ridge Cemetery | | 23d. LOCATION CITY OR TOWN Peachbottom Twp., York, PA | | 23e. COUNTY STATE | | 25a. DATE REC'D. BY REGISTRAR MAY 23 1986 | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| 24. FUNERAL DIRECTOR NAME John Harkins | | ADDRESS 600 Main Street Delta, PA 17314 | | | | | | | | | | | | | | | | | |
| DMMH - 17 (VR A15 ME (5)) | | | | | | | | | | | | | | | | | | | |

S. B. DODGE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual condition, the medical examiner should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------|-------------------|--|
| 8 6 1 4 0 5 9 REG. NO. | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST <u>Willie</u> <u>(WILWARD)</u> J. | | | MIDDLE | | | LAST <u>PRICE</u> | | | | | |
| 3. SEX <u>Male</u> | | | 4. RACE <u>black</u> | | | 5. DATE OF BIRTH MONTH <u>1</u> DAY <u>14</u> YEAR <u>17</u> | | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>69</u> YRS MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN. <u></u> | | | | | |
| 7a. BIRTHPLACE COUNTRY <u>Georgia</u> | | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>HARFORD</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <u>FALSTON</u> | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>FALSTON GENERAL HOSPITAL</u> | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Groundkeeper</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>2111 Jarrestsville Pike</u> | | | | | |
| 13a. STATE <u>Md</u> | | | 13b. COUNTY <u>BALTO</u> | | | 13c. CITY OR TOWN <u>Monkton</u> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE <u>3342 Jarrestsville Pike 21111</u> | | |
| 14. FATHER'S NAME FIRST <u>Will</u> | | | MIDDLE <u>James</u> | | | LAST <u>Price</u> | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Gertrude</u> | | | MIDDLE | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | | 16b. SOCIAL SECURITY NO. <u>257-36-239</u> | | | 17. INFORMANT <u>Deborah Nicholson</u> | | | ADDRESS <u>Wash D.C. Apt 618</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute wt</u> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Failure</u> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Metastatic Prostate Cancer</u> | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. <u></u> MONTH <u></u> DAY <u></u> YEAR <u>19</u> P.M. <u></u> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Paul Rivers</u> | | | 22c. DEGREE <u></u> | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22e. DATE SIGNED <u>5-13-86</u> | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Paul Rivers</u> | | | 22f. ADDRESS <u>3424 Sweet Av Rd 21131</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | 23b. DATE <u>5-17-86</u> | | | 23c. NAME OF CEMETERY OR CREMATORIAL <u>ST. James Church Cen</u> | | | 23d. LOCATION CITY OR TOWN <u>Monkton</u> | | | COUNTY | STATE <u>M.D.</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Wm. C. March</u> | | | ADDRESS <u>4300 Wabash Av</u> | | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 16 1986</u> | | | 25b. REGISTRAR'S SIGNATURE <u>Wm. C. March</u> | | | | | |

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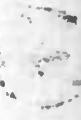
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR
STATE
REGISTRAR

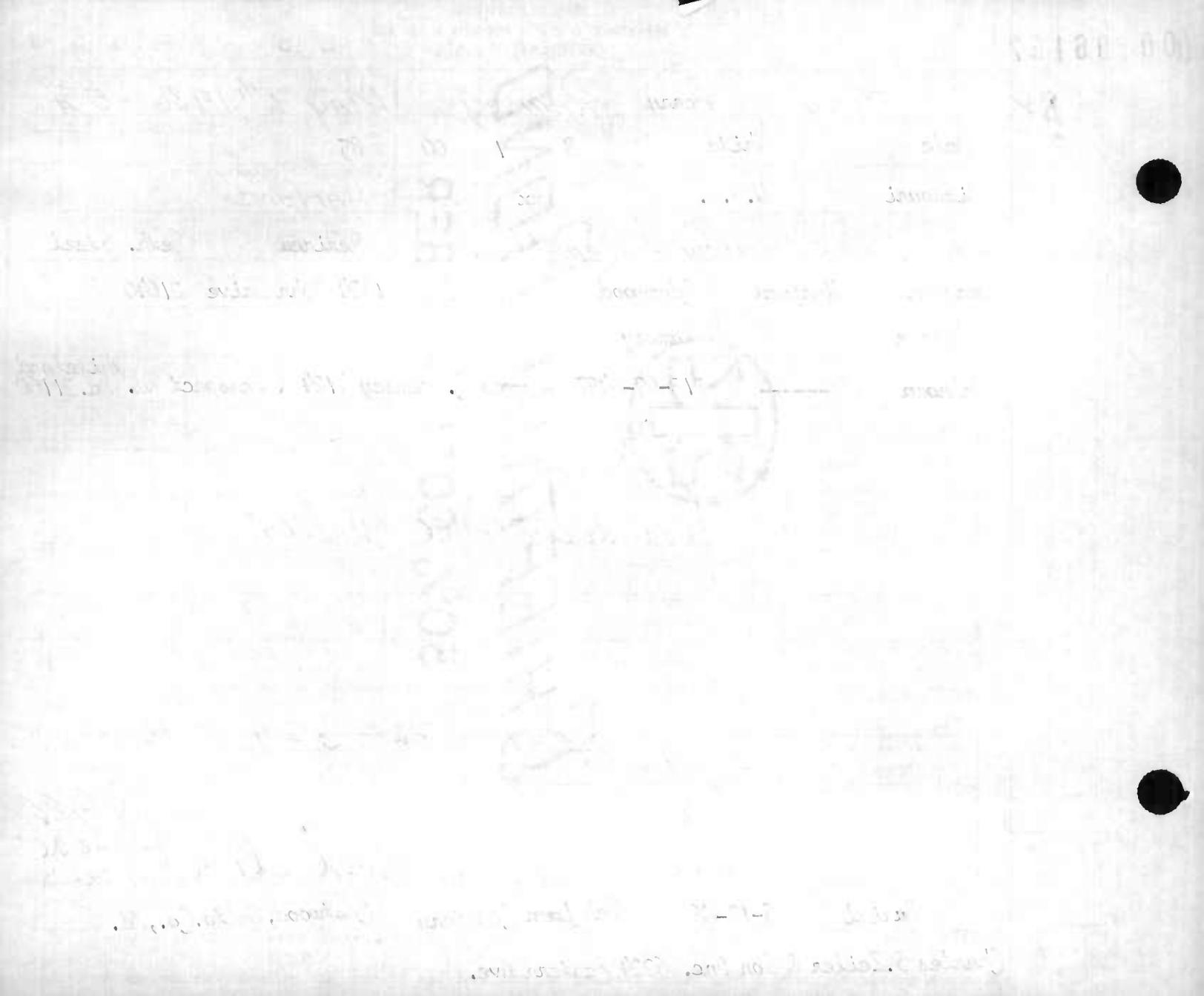
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 14060

| | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|------------------|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|------------------------------|-------------------------------------------------------------------|--------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | |
| <i>Tony</i> | | | <i>Perry</i> | <i>Ramsey</i> | | <i>May 9th, 1986</i> | | | | <i>5:30 PM</i> | |
| 3. SEX | | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| <i>Male</i> | | <i>White</i> | 8 | 1 | 00 | <i>85</i> | MONTHS | DAYS | HOURS | MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| <i>Missouri</i> | | <i>U.S.A.</i> | | | | <i>Harford</i> | MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | |
| <i>Havre de Grace</i> | | | | | | <i>Harford Mem. Hosp.</i> | | | | | |
| 13a. STATE | | | | | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| <i>Maryland</i> | | | | | | <i>Harford</i> | <i>Edgewood</i> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | <i>1824 John Drive 21040</i> | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) | | |
| <i>George</i> | | | | | | <i>Ramsey</i> | | | <i>Retired</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) | | | | | | 16b. SOCIAL SECURITY NO. | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| <i>Unknown</i> | | | | | | <i>213-09-0497</i> | | | <i>Beth. Steel</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for item 18, and item 18a) | | | | | | ADDRESS | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | <i>Whiteford</i> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASA</i> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Permanent pace maker</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | |
| 22a. I certify that (i) (this hospital) attended the deceased from <i>5-9-86</i> to <i>5-9-86</i> , that (ii) (we) last saw the deceased alive on <i>5-9-86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNATURE | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | <i>5-9-86</i> | | | |
| <i>J. T. Lee</i> | | | | | <i>Union Med. Ctr. Havre de Grace</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | 23e. DATE REC'D. BY REGISTRAR | | |
| <i>Burial</i> | | <i>5-12-86</i> | | <i>Oak Lawn Cemetery</i> | | | <i>Eastwood, Baltimore, Md.</i> | | 23f. REGISTRAR'S SIGNATURE | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | | | | | | | | |
| <i>Charles S. Zeiler & Son Inc.</i> | | <i>6224 Eastern Ave.</i> | | | | | | <i>MAY 12 1986</i> | | | |

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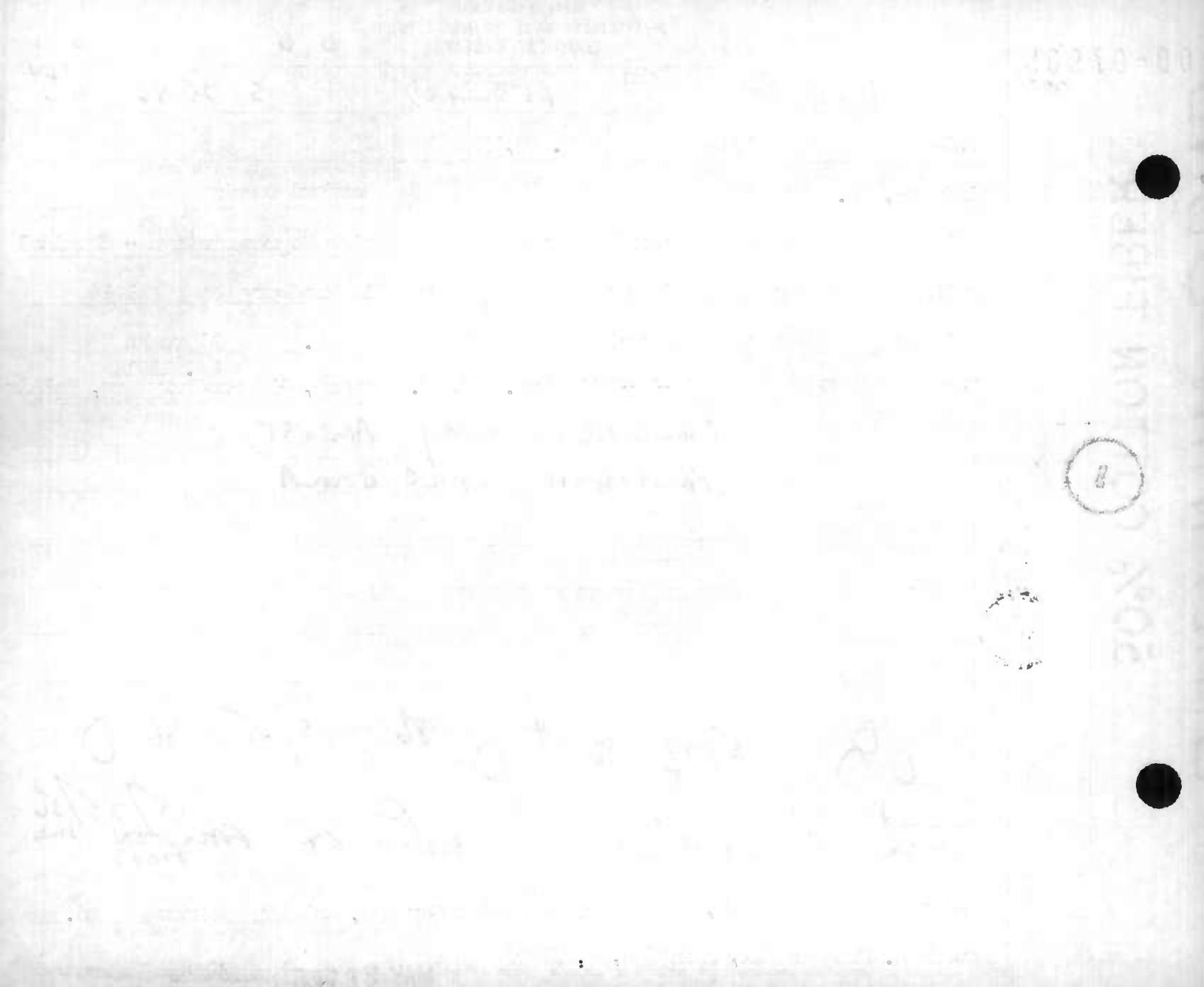


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then attach page 3 to the death certificate. Pages 1 and 2 should be filed within 72 hours after death.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 14661 | | | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------|--|-------------------------------|-------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------|--|--|
| 1 - STATE REGISTRAR | | | 2a DATE OF DEATH MONTH DAY YEAR 5 25 86 | | | | | | | | | 2b HOUR 9 AM | | | | | | | | | | | | | | |
| I DECEASED NAME (TYPE OR PRINT) Robert Requard | | | FIRST Robert MIDDLE John LAST Requard | | | 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 27, 1924 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS | | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | | | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County | | | 10. CITY OR TOWN OF DEATH Fallston | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Representative - Chemical | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Harford | | | 13c. CITY OR TOWN Bel Air | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 515 Woodbury Way 21014 | | | 14. FATHER'S NAME FIRST Louis MIDDLE Theodore LAST Requard | | | 15. MOTHER'S MAIDEN NAME FIRST Clara MIDDLE F. LAST Albrecht | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. WWII | | | 17. INFORMANT 219-16-7991 | | | 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PROSTATE CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) | | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21e. LOCATION STREET | | | 21f. CITY OR TOWNSHIP COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/20/86</u> to <u>3/25/86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated below. I will reside on <u>3/20/86</u> and view the body after death. | | | | | | | | | | | | 22b. DEGREE | | | 22c. ATTENDING PHYSICIAN | | | 22d. MEDICAL DIRECTOR | | | 22e. STAFF PHYSICIAN | | | 22f. DATE SIGNED <u>5/25/86</u> | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) Robert P. Edwards | | | 23b. ADDRESS 2112 BELAIR RD FALLSTON, MD 21047 | | | 23c. NAME OF CEMETERY OR CREMATORIAL GARDENS, BEL AIR HARFORD MD. | | | 23d. LOCATION CITY OR TOWN | | | 23e. COUNTY | | | 23f. STATE | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009 | | | 25a. DATE REC'D. BY REGISTRAR MAY 28, 1986 | | | 25b. REGISTRAR'S SIGNATURE | | | 25c. DATE REC'D. BY REGISTRAR | | | 25d. REGISTRAR'S SIGNATURE | | | 25e. DATE REC'D. BY REGISTRAR | | | | | | | | | | | |
| BP _____ | | | ADDRESS | | | NAME | | | ADDRESS | | | NAME | | | ADDRESS | | | NAME | | | | | | | | |
| DHMH - 16 60M 7-84 (VRA 15, 4) | | | | | | | | | | | | MAY 28, 1986 | | | MAY 28, 1986 | | | MAY 28, 1986 | | | MAY 28, 1986 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician (see page 3) and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the death certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 14062 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--|
| DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | DATE OF DEATH MONTH DAY YEAR | | | HOUR | | |
| GRANVILLE L. | | | Riley | | | MAY 14 1986 | | | 6:35 PM | | |
| 1. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| Male | | WHITE | | 12 17 1885 | | | 100 | | | | |
| 7a. BIRTHPLACE COUNTRY | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. KIND OF BUSINESS OR INDUSTRY | |
| PA. | | U. S. A. | | | | | Harford | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | |
| Lawre de Grace | | Harford Memorial Hospital | | FARMER | | | FARMER | | | | |
| 13a. STATE Md. | | 13b. COUNTY Cecil | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 185 Red Pump Rd. 21911 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ABRAHAM | | LOUISE | | | 213-20-2127 | | Pearl Durham | | 204 Red Pump Rd. Rising Sun, Md. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 16c. INFORMANT ADDRESS | | 17. INFORMANT ADDRESS | | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| N | | --- | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Cardiac arrest | | | | | | | | | |
| 887 | | DUE TO, OR AS A CONSEQUENCE OF Fracture left hip. S. & open reduction DUE TO, OR AS A CONSEQUENCE OF ASSTD | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-3 1986 to 5-14 1986, that (I) (we) lost saw the deceased alive on 5-14 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (I) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE J. Lee | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. ADDRESS Lindon Med. Ctr., Rising Sun, Md. | | | 22d. DATED AND SIGNED J. Lee | |
| 22e. PHYSICIAN'S NAME, TYPE OF PHYSICIAN J. Lee. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SELECT) | | 23b. DATE 5-17-86 | | 23c. NAME OF CEMETERY OR CREMATORIAL Brookview Cemetery | | | 23d. LOCATION Rising Sun, Cecil. Md. | | | | |
| 24. FUNERAL DIRECTOR NAME Richard L. Gordis | | ADDRESS Rising Sun, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 20 1986 | | | 25b. REGISTRAR'S SIGNATURE John R. Pendell | | | | |

1150-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be kept for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, medical certification is required.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 6 4 0 6 5 | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------|-------|------|------------------|--|
| | | | | | | | | | | REG. NO. | | | | | |
| 1 - STATE REGISTRAR | | | I. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| | | | Marie D. Russell | | | | | | May 6, 1986 | | | | | M | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER | YEAR | | IF UNDER 24 HRS. | |
| Female | | | White | | | MONTH DAY YEAR Oct. 9, 1916 | | | 69 | | MONTHS | YEARS | | HOURS MIN. | |
| 7a. BIRTHPLACE COUNTRY | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Md. | | | USA | | | | | | Harford County | | MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Bel Air | | | 1200 Bancroft Court | | | Hopkins Univ. Library | | | | | | | | | |
| 13a. STATE Md. | | | 13b. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 5521 Leith Rd. 21239 | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry Herman | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Agnes Kalendek | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) | | | 16b. SOCIAL SECURITY NO. 216-28-1972 | | | 17. INFORMANT Mr. E. Charles Russell Same as 13e | | | ADDRESS | | | | | | |
| no | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 weeks | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>Metastatic breast cancer</i> | | | | | | | | | | 7 years | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinomatous meningitis</i> | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>March 85</i> , 1985, to <i>May 86</i> , 1986, that (I) (we) lost saw the deceased alive on <i>April 25, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Paul Chang, MD</i> | | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED 5/1/86 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | Good Samaritan Professional Bldg. Balto. Md. | | | | | | | | | |
| Paul Chang MD | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIES Entombment | | | 23b. DATE May 9, 1986 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Dulaney Valley Mem. | | | 23d. LOCATION CITY OR TOWN | | COUNTY | STATE | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR MAY 7 1986 | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please remove the seal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal or removal of the medical remains. The medical remains should be turned over to the medical examiner for examination.

IMPORTANT: If Item 2 is marked on Item 18 shows any injury, or either trauma or removal of the body after death.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 6 1 4 6 6 4 | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|--|-------------------------------------------------------------------------------------------------|-----|----------------------------------------------------------|----------|--------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------|--|
| | | | | | | | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | | | | |
| MARY | | CATHERINE | | | | SAMMON | | 5 25 1986 | | | | | 9 05 AM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | | 9. IF UNDER 24 HRS | | | | | |
| Female | | White | | MONTH DAY YEAR May 23, 1902 | | 84 | | MONTHS DAYS | | MONTHS HOURS | | DAYS MIN. | | | | | |
| YRS. | | | | | | | | | | | | | | | | | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 11. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County | | | | | | | | | | | |
| Olyphant, Pa. | | USA | | | | | | | | | | | | | | | |
| 12. CITY OR TOWN OF DEATH | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 14. STATE Maryland | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Bel Air | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 17 Colonial Road 21014 | | 12b. KIND OF BUSINESS OR INDUSTRY --- | | | |
| Bel Air | | Bel Air Convalescent Center | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME FIRST | | MIDDLE | | LAST | | | | | | | |
| Michael | | — | | Nealon | | Catherine | | — | | Hoban | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 19. STREET ADDRESS / ZIP CODE | | 20. KIND OF BUSINESS OR INDUSTRY --- | | | | | | | |
| No | | 209-18-6394 | | Marie S. Kearney, 17 Colonial Road, Bel Air, Md | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> and <u>Diabetes</u> | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS | | | |
| | | | | | | | | | | | | | | 10 YRS | | | |
| | | | | | | | | | | | | | | 10 YRS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Small Stroke Syndrome</u> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/1/2</u> , 19 <u>84</u> , to <u>May 25</u> , 19 <u>86</u> , that (II) (we) lost saw the deceased alive on <u>May 20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Dudley Phillips, M.D.</u> | | | | | | | | | | | | | | DEGREE | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) Dudley Phillips, M.D. | | | | | | | | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED 5-25-86 | |
| 22e. ADDRESS Masonic Bldg., Darlington, Md. 21034 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE May 27, 1986 | | 23c. NAME OF CEMETERY OR CREMATORIUM St. Patrick's Cemetery | | 23d. LOCATION CITY OR TOWN Olyphant | | COUNTY | | STATE | | | | | | | |
| Burial | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009 | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR MAY 28 1986 | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/trust permit. Then please remove carbon paper. Pages 1 and 2 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death. Page 4 may be retained by the funeral director, page 1.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 6 1 4 6 6 5 REG. NO. | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------|-------------------------------------------------|------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 1. SEX | | | 2. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| Edward W. Hartman | | | Male | | | October 10, 1986 | | | 5 | 8 | 86 | 9 = 160 M | |
| 3. RACE | | | 4. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 21 HRS | | |
| White | | | Month Day Year October 10, 1913 | | | 72 YRS | | | MONTHS | DAYS | MONTHS | HOURS | MIN. |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | |
| Maryland | | | USA | | | | | | Harford | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Harford Grace | | | Harford Memorial Hospital | | | Passenger Cond. | | | Penn Central RR | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE | | | 21903 | |
| Md. | | | Cecil | | | Perrysville | | | 99 Blythedale Rd. | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) | | | 17. INFORMANT | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Alexander Jackson | | | Addie Helen Gillespie | | | 16b. SOCIAL SECURITY NO. 716-01-7333 | | | Gladys C. Sentman, 99 Blythedale Road | | | Perryville, Md. 21903 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | Acute cardiac arrest | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) Acute cardiogenic shock | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial infarction with pericardial | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION (ENTER IN PART II) | | | | | | | | | | of Chronic obstructive pulmonary disease | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II) | | | | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> NOT WHILE AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>5-8-1986</u> to <u>5-8-1986</u> , that (I) (we) last saw the deceased alive on <u>5-8-1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | 22b. DATE SIGNED 5-8-86 | | | |
| 22c. SIGNATURE Dr. S. J. - | | | | | | | | | | DEGREE | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. YAMAKAWA M.D. 319 So. Union Ave. Harford Grace | | | | | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Burial | | | May 12, 1986 Hopewell Cem. | | | | | | Port Deposit Cecil Md. | | | | |
| 24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md. | | | | | | | | | | 25. DATE REC'D. BY REGISTRAR / REGISTRAR'S SIGNATURE MAY 13 1986 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove page 3 and attach page 2, should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, an other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------|--|
| 8 6 1 4 0 6 6 REG. NO. | | | | | | | | | | | | |
| DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | DATE OF DEATH MONTH DAY YEAR | | | 2b HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | MATHEW FRANK SKORUPSKI | | | May 15 1986 | | | 3:40 AM | | | |
| 3. SEX: | | 4. RACE: | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| Male | | White | | Aug. 23, 1899 | | | 86 | | | | | |
| 7. BIRTHPLACE COUNTRY | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Buffalo, N.Y. | | USA | | | | | | Harford | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Fallston | | Fallston Gen. Hospital | | | Auto Tire Dealer | | | Tire Sales | | | | |
| 13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | |
| 14. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | 13f. ADDRESS | | |
| Maryland | | Harford | | Bel Air | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 300 Sunflower Court 21014 | | Joppatowne, Md. 21085 | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME FIRST | | MIDDLE | | LAST | | |
| Lawrence | | — | | Skorupski | | Josephine | | — | | Bakos | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| No | | | 081-28-6703 | | | Daniel M. Skorupski, 412 Haverhill Road | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. | | | | | | | | | | | | |
| (b) <u>congestive heart failure</u> | | | | | | | | | | | | |
| (c) <u>pneumonia</u> | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>5/14</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Andrew Nowakowski</u> | | | DEGREE <u>MD</u> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <u>5/15/86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Andrew Nowakowski MD</u> | | | 22e. ADDRESS <u>125 N. MAIN ST. BEL-AIR, MD 21015</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE May 17, 1986 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Cemetery St. Stanislaus Catholic Cheektowaga - Erie - N.Y. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME <u>Howard K. McComas III</u> | | | ADDRESS <u>Abingdon, Md. 21009</u> | | | 25a. DATE REC'D. BY REGISTRAR MAY 16 1986 | | | 25b. REGISTRAR'S SIGNATURE <u>Julie Davidson-Rendell</u> | | | |

10000-00

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
MAY 1968



00-06079

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

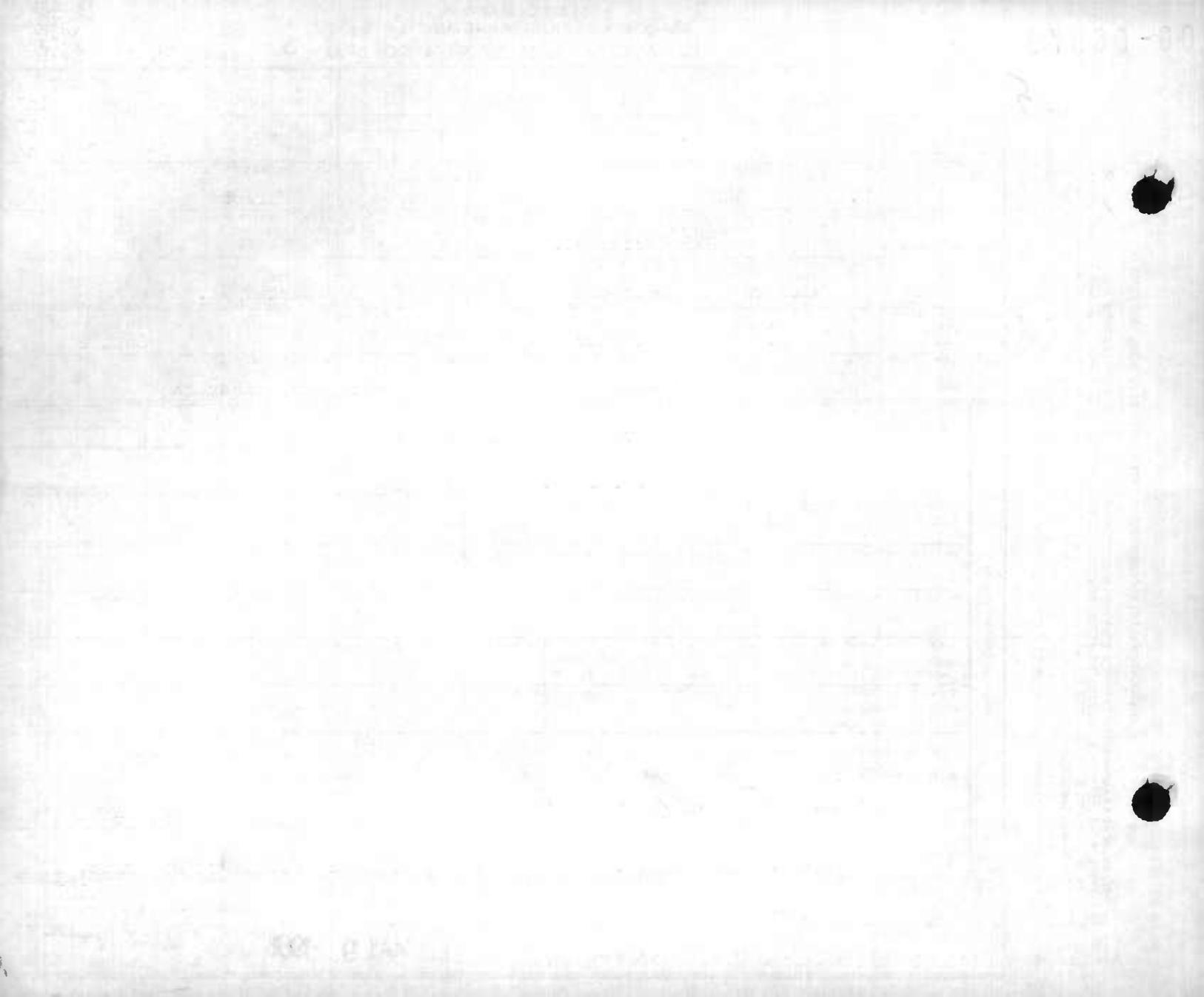
REG. NO. 4667

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 2101 W. PRESTON ST., BALTIMORE, MD. 21201.
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------|------------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|--|--|-------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF EST- DEATH MATED | | | 2b. HOUR MONTH DAY YEAR | | | | |
| Helen Ruth Smith | | | | | | <input checked="" type="checkbox"/> 5-5 1986 | | | 1a 30 M | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN. | | | | 2c. DATE PRONOUNCED DEAD | | | | |
| F | W | 3 17 22 | 64 YRS. | | | | | | 5-5 1986 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| W. VA | | | USA | | | | | | Harford | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Aberdeen | | | 353 Carter St. | | | Homemaker | | | | | | | |
| 13a. STATE MD | | | 13b. COUNTY Harford | | | 13c. CITY OR TOWN Aberdeen | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| | | | | | | | | | 13e. STREET ADDRESS 353 Carter St. 21001 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | |
| Carl S. Stutler | | | Dolly Suttle | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. N/A | | | 17. INFORMANT Det. S. Smith (Son) Aberdeen | | | ADDRESS | | | | |
| | | | 236-20-5383 | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last. (b) A.S.C.V.D.- Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> | | | | | | and in my opinion | | | | |
| ACTUAL SIGNATURE <i>Luis E. Renjel</i> | | | | | | TITLE (SPECIFY) M.D. Deputy | | | MEDICAL EXAMINER | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | Luis E. Renjel, M.D. | | | ADDRESS 464 Alliance St. Havre De Grace, MD | | | DATE SIGNED 5-5-86 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE May 8, 1986 | | | 23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gdns. | | | 23d. LOCATION CITY OR TOWN Bel Air, Harford, Maryland | | | 21078 | |
| Burial | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR MAY 9 1986 | | | 25b. REGISTRAR'S SIGNATURE <i>Jeanne S. Pendleton</i> | | | | |
| Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399 | | | | | | | | | | | | | |



00-07858

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed, it should be retained for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, or removed.

IMPORTANT: If item 18 is marked as shown, injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6
REG. NO.

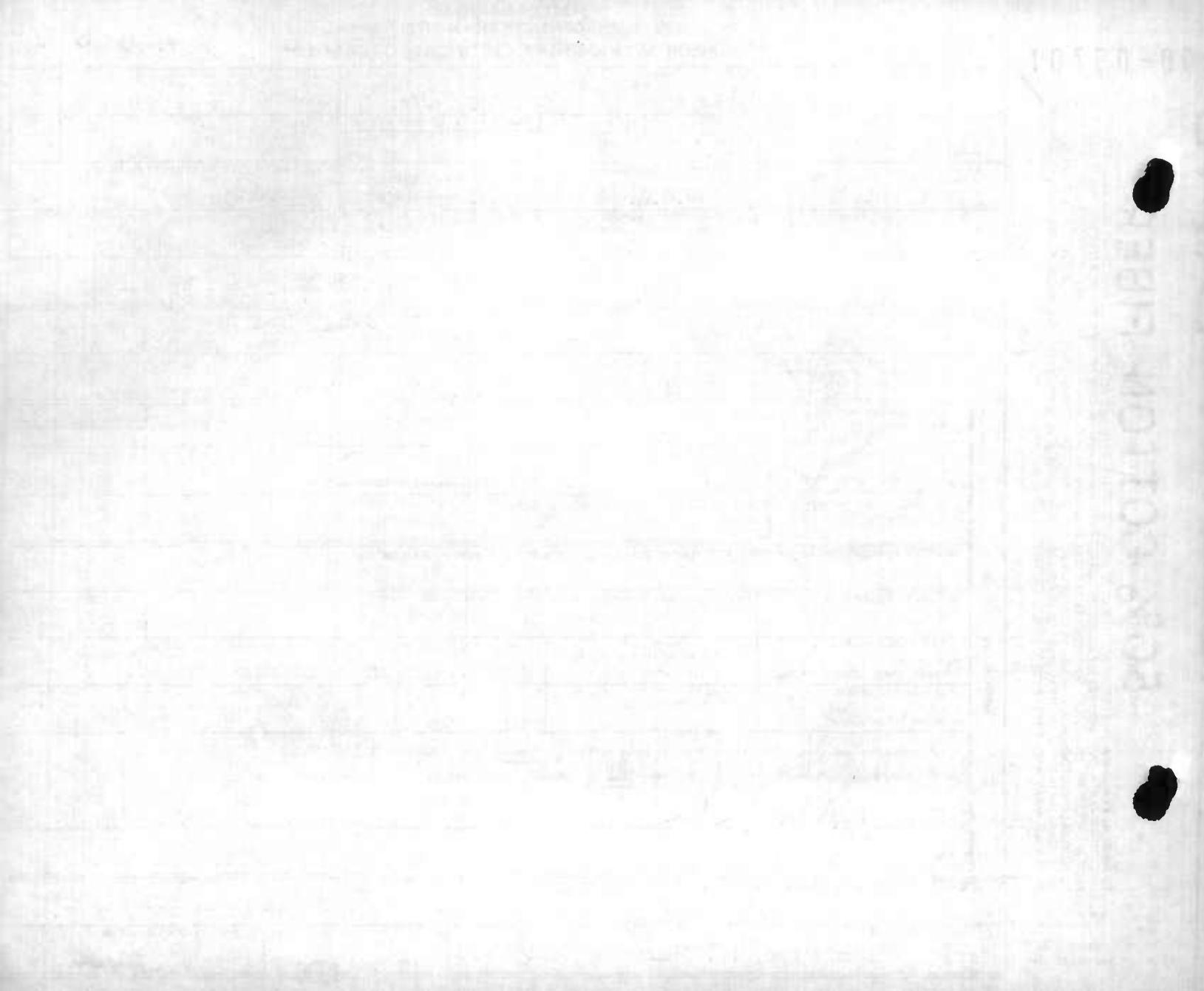
1 4 0 6 8

| | | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | | |
| <i>Clyde R Spyder</i> | | | | | | <i>May 21 1986</i> | | | | 45 12 AM | | |
| 3. SEX | | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| <i>Male</i> | | <i>White</i> | <i>March 7, 1908</i> | | | <i>78</i> | MONTHS | YEARS | MONTHS | YEARS | | |
| 7a. BIRTHPLACE COUNTRY | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| <i>Pa.</i> | | <i>U.S.A.</i> | | | | | | | <i>Harford</i> | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| <i>Harford de Grace</i> | | | <i>Harford Mem. Hospital</i> | | | | | <i>Maint. Manager</i> | | | <i>Long Home</i> | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS / ZIP CODE | | |
| <i>Maryland</i> | | | <i>Cecil</i> | | <i>Perryville</i> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | <i>P.o. Box 364 21903</i> | | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | 15. MOTHER'S M AIDEN NAME | | | 16. ADDRESS | | | |
| <i>Calvin</i> | | | | | <i>Snyder</i> | <i>Minnie</i> | | | <i>Ritter</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| <i>No</i> | | | <i>196-10-2833</i> | | | <i>Mabel E. Snyder, Perryville, Maryland.</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for item (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | <i>Malignant mesothelioma with pleuro-pulmonary metastasis</i> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. | | | DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | |
| <i>Arteriosclerotic cardiovascular disease</i> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from <i>5-18 86</i> to <i>5-21 86</i> , that (i) (we) last saw the deceased alive on <i>5-21 86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | | | | | | | |
| <i>Dr. W. K. Patterson</i> | | | <i>M.D.</i> | | | | | | | | | |
| 22c. ADDRESS | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | |
| <i>308 S. Union Ave. Harford de Grace</i> | | | <i>May 21, 86</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL <i>Burial</i> | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL <i>Conestoga Mem. Park</i> | | | 23d. LOCATION CITY OR TOWN <i>Lancaster</i> COUNTY <i>Lancaster, Pa.</i> STATE | | | |
| 24. FUNERAL DIRECTOR <i>Lee A. Patterson</i> | | | ADDRESS <i>Lee A. Patterson & Son, Perryville, Maryland</i> | | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 28 1986</i> | | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Patterson</i> | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201, BALTIMORE, MARYLAND.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 4669 | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR | | | | | |
| RUSSELL | | | Eugene | | | | | | SPIKER, Jr. | | | 5 10 1986 M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YR. <input type="checkbox"/> IF UNDER 24 HRS MONTHS DAYS HOURS MIN | | 2b. HOUR MONTH DAY YEAR | | | | | |
| Male | | White | | Jan. 29, 1960 | | | 26 yrs. | | | | | 2d. HOUR 9:25 AM | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | |
| Pennsylvania | | U.S.A. | | | | | | | | Harford County | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | |
| Aberdeen | | Chesapeake Bay | | | | | | | | | | Machinist | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | | |
| Pennsylvania | | Lancaster | | MT. Joy | | | | | 122 E. Donegal St. /17552 | | | | | | | | |
| 14. FATHER'S NAME | | FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES <input checked="" type="checkbox"/> 1981-1983 | | | | 16b. SOCIAL SECURITY NO. 165-54-3034 | | 17. INFORMANT E.R. Spiker, Same As Above | | | |
| | | Eugene Russell Spiker | | | Milly | | | | | | | ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9108 IMMEDIATE CAUSE (a) Drowning Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) } DUE TO, OR AS A CONSEQUENCE OF (c) } DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5-10- 1986 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject drowned when canoe capsized. | | | 21d. LOCATION STREET Chesapeake Bay near water | | | | CITY OR TOWN Turkey Point Inquiry and in my opinion | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY Cecil | | | | STATE MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held an | | 22b. Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | TITLE (SPECIFY) M.D. Assistant | | | MEDICAL EXAMINER | | | | DATE SIGNED 5-27-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Ann M. Dixon, M.D. | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE Removal/Cremation May 28, 1986 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Greenwood Crematory | | | 23d. LOCATION CITY OR TOWN Lancaster, Lancaster, Penna. | | COUNTY STATE | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1986 | | 25b. REGISTRAR'S SIGNATURE John D. Tarring | | | | | | | |
| 07 BY 25M BP | | | | | | | | | | | | | | | | | |
| DHMH - 17 (VR A15 ME (5)) | | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove entire papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 86 14610 | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------|--|--|----------------------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | 2. DATE OF DEATH MONTH DAY YEAR 5/26/86 | | | | | | | | | 2b. HOUR 5 A.M. | | | | | | | | | | | |
| I. DECEASED NAME (TYPE OR PRINT) | | | FIRST Kathleen Iris STEARNS | | | LAST STEARNS | | | 3. SEX FEMALE | | | 4. RACE White | | | 5. DATE OF BIRTH July 6, 1896 | | | 6. AGE IN YEARS LAST BIRTHDAY Born July 6, 1896 88 (1896) 75 | | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD. | | | | | | | | | | | | | | |
| 11. CITY OR TOWN OF DEATH Fallston | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hosp | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE | | | 12b. KIND OF BUSINESS OR INDUSTRY Medical | | | | | | | | |
| 13. STATE Maryland | | | 13b. COUNTY Harford Co. | | | 13c. CITY OR TOWN Bel Air | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 103 DONZEN DRIVE - Apt. D | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST Thomas MIDDLE Reginald LAST Taylor | | | 15. MOTHER'S MAIDEN NAME UNKNOWN | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 520-28-4258 | | | | | | | | | 17. INFORMANT (Husband) 838-2092 ADDRESS Mr. Thomas P. STEARNS 103 DONZEN DRIVE - Apt. D Bel Air, Maryland 21014 | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 101, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (i) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death | | | | | | | | | | | | 22c. DATE SIGNED 5/26/86 | | | | | | | | | | | |
| 22b. SIGNATURE John Merillat MD | | | 22d. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MERILLAT MD | | | 22f. ADDRESS | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE May 28 1986 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Crematory | | | 23d. LOCATION Baltimore, Maryland | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Joseph William Foster 504 W. Broadway & Williams St. Bel Air, Maryland 21014 | | | 25a. DATE REC'D. BY REGISTRAR MAY 28 1986 | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Julie Darden-Pond | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |

11280-00

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifying physician should be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 86 14671 | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|--|-----------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------|--|--|--------------------|-----|------|----------|--|--|
| 1 - STATE REGISTRAR | REG. NO. | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | |
| Nilah Loree Steinkamp | | | | | | | | | | | | 5 | | | 4 | 86 | | 10:45A | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | | 8. IF UNDER 24 HRS | | | | | |
| FEMALE | | | WHITE | | | MONTH JUNE | | | YEAR 26, 1901 | | | 84 | | | YRS | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| INDIANA | | | U.S.A. | | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Harford | | | MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Fallston | | | Fallston General Hospital | | | HOMEMAKER | | | | | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS / ZIP CODE | | | 21084 | | | | | |
| MARYLAND | | | Harford | | | JARRETSVILLE | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 3853 OLD FEDERAL HILL RD., | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| THEODORE F. | | | ABIGAIL | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| NO | | | N/A | | | 304-22-3355 | | | LELAND O. VAUGHAN, SAME AS ABOVE | | | | | | | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY FAILURE</u> | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>PULMONARY CONGESTION & EMBOLISM</u> | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>LARGE DIAPHRAGMATIC HERNIA</u> • <u>Other surgery - open reduction & fixation</u> | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 4/26/86 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED UNSTABLE INTERSTITIAL PULMONARY FIBROSIS | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS DUE TO <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR <u>5:30</u> P.M. MONTH <u>4</u> DAY <u>23</u> YEAR <u>1986</u> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Fell at home | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) HOME | | | 21f. LOCATION STREET 3853 OLD FEDERAL HILL RD. HARF. MDT. CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>4/24/86</u> to <u>5/4/86</u> , that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <u>4/23/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE A. S. Barretto | | | 22c. DEGREE MD | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> | | | 22e. DATE SIGNED 5/4/86 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL / BURIAL | | | 23b. DATE MAY 6, 1986 | | | 23c. NAME OF CEMETERY OR CREMATORIAL HILL CREST CEMETERY | | | 23d. LOCATION CITY OR TOWN REDKEY | | | 23e. COUNTY JAY, INDIANA | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME TARRING FUNERAL HOME, P.A., ABERDEEN, MD. 21001-3315 | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR MAY 8 1986 | | | 25b. REGISTRAR'S SIGNATURE John Tarrin | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 14072 | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------|------------------------------------------------------------------|--------------|----------------------------------------------|---------------------------------------------|------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2d. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | |
| FRANK S | | | | | | | | | STRELLA | | | 5 | 17 | 86 | | 745P M | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Male | | | White | | | MONTH DAY YEAR | | | 82 | | | MONTHS | DAYS | HOURS | MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 | | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Czechoslovakia | | | U.S. A. | | | | | | | | | Harford County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | |
| FALLSTON | | | FALLSTON GENERAL HOSPITAL | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Harford | | | 13c. CITY OR TOWN Joppa | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 328 Hardwicke Place, 21085 | | | | | |
| 14. FATHER'S NAME FIRST Joseph | | | MIDDLE Strella | | | 15. MOTHER'S MAIDEN NAME FIRST Mary | | | | | | Authority | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | 328 Hardwicke Place | | | | | |
| no | | | 089-09-4161 A | | | Mrs. Josephine B. Strella, Joppa, Md. 21085 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and c) PART 1. DEATH WAS CAUSED BY | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| IMMEDIATE CAUSE (a) <i>Endocarditis</i> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. | | | | | | | | | | | | | | | | | |
| (b) <i>Arteriosclerosis</i> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ascorbic Acid Deficiency</i> | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Arteriosclerosis, hypertension, CVA</i> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>5/12/86</i> and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>MS</i> | | | | | | | | | | | | 22c. DEGREE | | | | | |
| 22d. PHYSICIAN'S NAME <i>MS</i> | | | | | | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> | | MEDICAL DIRECTOR <input type="checkbox"/> | STAFF PHYSICIAN <input type="checkbox"/> | 22e. DATE SIGNED | |
| 22e. ADDRESS <i>2112 Belair Road</i> | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE Burial 5-21-1986 | | | 23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph Ch. Cem. | | | 23d. LOCATION CITY OR TOWN Fullerton | | | COUNTY Baltimore | STATE Md. | | | | |
| 24. FUNERAL DIRECTOR NAME E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087 | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR MAY 23 1986 | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |

200 ESTIMATED

TO HOSPITAL OR ATTENDING PHYSICIAN. The 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove stationers paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPROVING HUMAN-ROBOT TEAMWORK

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

40 / 3

| | | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------|------------------------|------------------------|---------|--|
| 1. DECEASED NAME [TYPE OR PRINT] | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | MONTH | DAY | YEAR | 2b HOUR <u>17</u> | | |
| Robert A. TARBERT | | | | | | 5 | 13 | 86 | | 11 PM | | |
| 3. SEX | | 4 RACE | | 5. DATE OF BIRTH | | | 6. AGE [IN YEARS LAST BIRTHDAY] | | | IF UNDER 1 YEAR | | |
| Male | | White | | MONTH | DAY | YEAR | 58 | | | IF UNDER 24 HRS | | |
| 7a BIRTHPLACE [STATE OR FOREIGN COUNTRY] | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | MONTHS DAYS HOURS MIN. | | |
| Maryland | | United States | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Harford County MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Fallston | | Fallston Gen. Hospital | | Security Guard | | | Security | | | | | |
| USUAL RESIDENCE [IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION] | | | | | | 13a. STREET ADDRESS / ZIP CODE | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | 1550 Main Street/21160 | | | |
| Maryland | | Harford | | Whiteford | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 14 FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST | | | MIDDLE | LAST | FIRST | | | MIDDLE | LAST | | | |
| Robert | | | R. | Tarbert | Catherine | | | M. | Quickel | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? [YES NO OR UNKNOWN] | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | |
| Yes | | | | | | W.W. 2 217-20-5875 | | | | | | |
| 17 INFORMANT | | | | | | ADDRESS | | | | | | |
| Marlene P. Tarbert | | | | | | Whiteford, MD | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Pericardial Tamponade</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic Pericarditis</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septicemia</u> | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | |
| Acute Respiratory Distress Syndrome, Septic Shock, Acute Tubular Necrosis | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22d. DATE SIGNED | | | | |
| George Laws, MD | | | | | | | | | | | 5-14-86 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIUM | | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | |
| Burial | | 5/17/86 | | Slate Ridge Cemetery | | | Peachbottom Twp., York, PA | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| John Harkins | | 600 Main St. Delta, PA 17314 | | | MAY 19 1986 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be detached for use as the burial-transit permit. Then please return the copy to the physician. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 14674 | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------|------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Dominic Turturro | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 22 86 | 2b. HOUR 8:30 A.M. | | | |
| 3. SEX M ale | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 12 06 03 | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford | MD. | | | |
| 10. CITY OR TOWN OF DEATH Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Theatre Manager | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY Theatre | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. 13c. COUNTY Harford 13d. CITY OR TOWN Edgewood | | | 13e. STREET ADDRESS / ZIP CODE 706 Tulip Ct. 21040 | | | |
| 14. FATHER'S NAME FIRST Michael | MIDDLE | LAST Turturro | 15. MOTHER'S MAIDEN NAME FIRST Rosario | MIDDLE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 026-12-5391 | 17. INFORMANT Barbara Broman (dghtr) | ADDRESS 4504 Fieldgreen Rd. 21236 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Resection of abdominal aortic aneurysm | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a. DATE OF OPERATION 5-14-86 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal aortic aneurysm | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/13/86 , 19 86 , to 5/22 , 19 86 , that (I) (we) last saw the deceased alive on 5/22 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Arnold | | | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> | MEDICAL DIRECTOR <input type="checkbox"/> | STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 5/22/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) I.D. SOMERVILLE | | | 22e. ADDRESS 400 LEWIS ST HAVRE DE GRANGE | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIAL) Removal | 23b. DATE 5/22/86 | 23c. NAME OF CEMETERY OR CREMATORIAL St. Johns Cemetery | 23d. LOCATION CITY OR TOWN Worcester | STATE Mass. | | | |
| 24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. | 25a. DATE REC'D. BY REGISTRAR 9705 Belair Rd., Balt. Md. 21230 | 25b. REGISTRAR'S SIGNATURE MAY 23 1986 | | | | | |

2008 COOL GM. 1600



00-06545

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 14675

REG. NO.

1-
FOR
STATE
REGISTRAR

| | | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST FELIX | MIDDLE VALI | LAST VALI | 2a. DATE OF DEATH MONTH DAY YEAR 5-12-86 | MONTH DAY YEAR | 2b. HOUR 820P.M. | | | | |
| 3. SEX MALE | | | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR June 30, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 89 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Estonia | | | 7b. CITIZEN OF WHAT COUNTRY? Estonia | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH FALLSTON | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheet Metal Man | | | | |
| 13a. STATE Md. | | | 13b. COUNTY Harford | 13c. CITY OR TOWN FALLSTON | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 13414 Bottom Rd. 21082 | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 14. FATHER'S NAME FIRST Jaan | | | MIDDLE Vali | LAST Liis | 15. MOTHER'S MAIDEN NAME FIRST Kask | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. 216-30-5069 | | 17. INFORMANT Viktor Vali 13414 Bottom Rd. 21082 | | ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> Conditions, if any, which gave rise to immediate cause (b) <u>MASSIVE BRAINSTEM CVA</u> <u>days</u> . DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEOSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>year</u> . (c) <u>ATHEOSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>year</u> . | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | STATE | | |
| 22a. I certify that (i) (this hospital) attended the deceased from <u>5/10</u> , 19 <u>86</u> , to <u>5/12</u> , 19 <u>86</u> , that (ii) (we) last saw the deceased alive on <u>5/12</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (ii) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Barry A. Wohl</u> | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-13-86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY A. WOHL M.D. | | | 22e. ADDRESS 2003 Rockserair Rd. Forest Hill, MD 21050 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE May 16, 86 | | 23c. NAME OF CEMETERY OR CREMATORIAL Westview Crematory | | 23d. LOCATION CITY OR TOWN Baltimore, Md. | | COUNTY | STATE | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. 5305 Harford Rd. 21214 | | | 25a. DATE 25b. REGISTRATION REGISTRAR'S SIGNATURE | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the burial permit. Then please send to the funeral director. Pages 1 and 2 should be filed within 90 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. If any injury, or other transaction, in the medical examination of the deceased, is not noted on this certificate, the medical examiner may be asked to make a separate report.

1630-0

1000 300 x 270

0-08509

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be remitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove this document. Page 1 and 2 should be held with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 2 is marked or Item 18 shows any injury or other traumatic event, the medical certifying physician must sign the certificate.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 85-14016 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------|-------------------------------------------------------------------------------------------------------------------------------|--|-------|---------------------------------------|-------|-------------------------------------------------|------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| MARIE D. VOGT | | | | | | 5-19-86 | | | 5 | 19 | 86 | 11 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | MONTH DAY YEAR | | | 88 | | | MONTHS | YEARS | HOURS | MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | |
| Baltimore | | U. S. A. | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | HARFORD | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| FALLSTON | | Fallston General Hospital | | House wife | | | Home | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Joppa | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS 2509 Loloa Dr. | | 21087 | |
| 14. FATHER'S NAME William | | MIDDLE Henry | | LAST Darhey | | | 15. MOTHER'S MAIDEN NAME Anna | | | Marie | | Petri | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | | ADDRESS 2509 Loloa Dr. | | | | | | |
| no | | 217-46-2361 | | Mr. Guilfred L. Vogt, Kingsville, Md. 21087 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cause respiratory collapse</i> | | | | | | | | | | | | | |
| 887 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>cardinal vascular accident</i> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Fractured right leg</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fx leg</i> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/19/86</i> to <i>5/19/86</i> , that (I) (we) last saw the deceased alive on <i>5/19/86</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. DEGREE | | 22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED | | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Skelton</i> | | 22f. ADDRESS <i>1327 Belair Rd</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-22-1986 | | 23c. NAME OF CEMETERY OR CREMATORIAL Parkwood | | | 23d. LOCATION CITY OR TOWN Parkville | | | COUNTY Baltimore Co. Md. | | STATE | |
| 24. FUNERAL DIRECTOR E.F. ^{NAME} Lassahn Funeral Home, 11750 Belair Rd. Kingsville | | 25a. DATE REC'D. BY REGISTRAR MAY 23 1986 | | 25b. REGISTRAR'S SIGNATURE <i>Juli Davidson</i> | | | | | | | | | |
| | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove this page and attach pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at 301-653-2635.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8014671 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------|-----------|----------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | |
| Elizabeth E. Watters | | | | | | May 17 1986 | | | 6:00 P.M. | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| 7b. BIRTHPLACE COUNTRY MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | SEPTEMBER 23, 1902 | | | 83 YRS. | | | 8. IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford | |
| 13a. STATE MO | | 13b. COUNTY HARFORD | | 13c. CITY OR TOWN HAVRE de GRACE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 100 REVOLUTION STREET | | 12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC WORK | |
| 14. FATHER'S NAME HARRY | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME SARA | | MIDDLE | | LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212 32 3919 | | 17. INFORMANT PATRICIA COULTER 214 EOMUNO STREET ABEROEEEN, MD. 21001 | | ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for items (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinomatosis, intraabdominal</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Lionyosarcome</i> Since 5/85 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Lionyosarcome</i> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Lionyosarcome</i> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Renal failure, acute & sepsis.</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20. IF AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5 - 17 1986, to 5 - 17 1986, that (I) (we) last saw the deceased alive on 5 - 17 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Edward C. Loo, M.D.</i> | | 22c. DEGREE M.D. | | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22e. DATE SIGNED 5/17/86 | | | | | |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edward C. Loo, M.D.</i> | | 22g. ADDRESS Havre de Grace, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 20MAY86 | | 23c. NAME OF CEMETERY OR CREMATORIAL ANGEL HILL CEMETERY | | 23d. LOCATION CITY OR TOWN HARFORD CO., MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE DE GRACE, MO. 21078 | | 25a. DATE REC'D. BY REGISTRAR MAY 20 1986 | | 25b. REGISTRAR'S SIGNATURE <i>John Mitchell</i> | | | | | | | |

31150-00

65

00-06158

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Please send a copy of page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is checked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------------|--------|----------|-------------------------------------------------|
| 8 6 1 4 6 7 8 | | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | |
| Veola St. Whittington | | | | | | | | | | | | |
| 3. SEX | | | 4 RACE | | | 5. DATE OF BIRTH | | | 20. DATE OF DEATH | | | |
| Female | | | Negro | | | Month Year | | | Month Day Year | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 21b. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | |
| Md. | | | U. S. A. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bel Air | | | 102 N. Bond St. | | | Ret. Teacher | | | Bd of Ed. | | | |
| 13. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS |
| Maryland | | | Baltimore | | | Bel Air | | | | | | 102 N. Bond St. 21014 |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| George | | | Laura | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | |
| No | | | 212-38-2507 | | | Cose L. Preskerry - Bel Air, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple myeloma</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b), | | | | | | | | | | | | 3 years |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c), | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>coronary artery disease</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>J. de Alonzo</u> | | | 22c. DEGREE <u>as M</u> | | | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22e. DATE SIGNED <u>28/5/86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. de Alonzo SANTOS</u> | | | 22e. ADDRESS <u>2835 Cypress St., Bel Air, Md.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE <u>May 9, 86</u> | | | 23c. NAME OF CEMETERY OR CREMATORIAL <u>Clark's United Cemetery, Bel Air</u> | | | 23d. LOCATION CITY OR TOWN <u>Harford Md</u> | | | |
| 24. FUNERAL DIRECTOR <u>Gloria J. Bullock - Home of Grace, Md.</u> | | | 24b. ADDRESS <u>2107 75th St., Bel Air, Md.</u> | | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 09 1986</u> | | | 25b. REGISTRAR'S SIGNATURE <u>Gloria J. Bullock</u> | | | |

2020 VAT

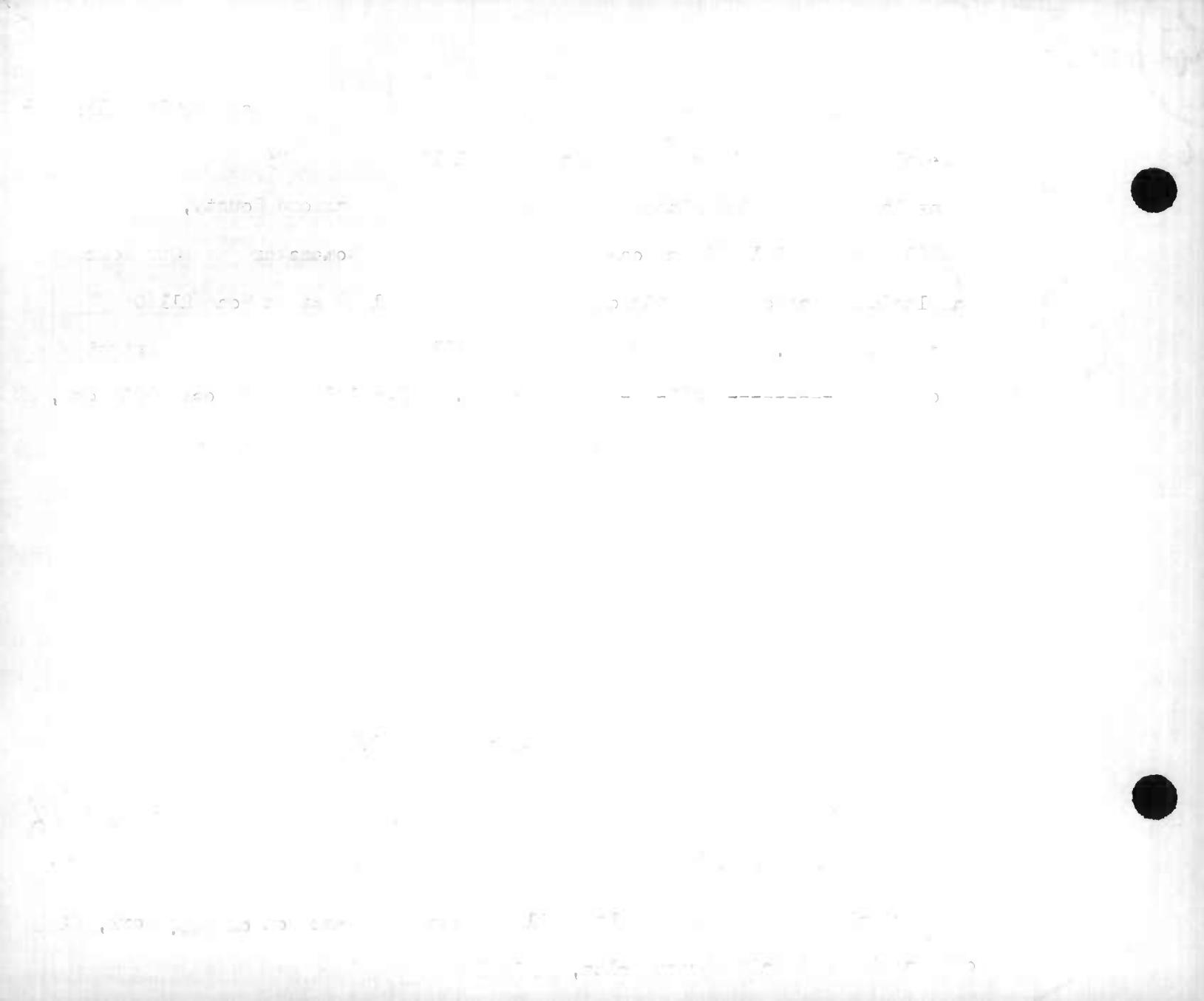
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical examiner's name and address must be noted on this page.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 6 1 4 0 7 9 | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------|-------|-------------------------------------------------------------------------------------|------|-----------------|------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| MARY AGNES WILLIAMS | | | | | | May 27 1986 | | | | | | 12:35 a | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | Jan 8 1911 | | | 75 YRS. | | | MONTHS | DAYS | HOURS | MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | |
| Maryland | | United States | | | | | Harford County, | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Whiteford | | 1810 Ridge Road | | | | | Homemaker | | | Own Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13e. STREET ADDRESS / ZIP CODE | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Maryland | | Harford | | Whiteford | | | | | | 1804 Ridge Road/21160 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S M AIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | |
| James H. Heaps | | Bill Knight | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| No | | 212-48-7885 | | June L. Atkins | | 1810 Ridge Road Whiteford, MD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| Metastatic carcinoma of uterus | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/6 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED 5/27/86 | | | |
| 22b. SIGNATURE Brian T. Yeo, M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brian T. Yeo, M.D. | | 22e. ADDRESS 801 S. Union Ave., Havre de Grace, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/30/86 | | 23c. NAME OF CEMETERY OR CREMATORIUM Slateville Cemetery | | 23d. LOCATION CITY OR TOWN Peachbottom Twp., York, PA | | | | | | | |
| 24 FUNERAL DIRECTOR NAME John Harkins ADDRESS 600 Main Street Delta, PA 17314 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE John Davidson Pendleton | | | |



00-07248

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACES PROVIDED. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSPORT PERMIT. AGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

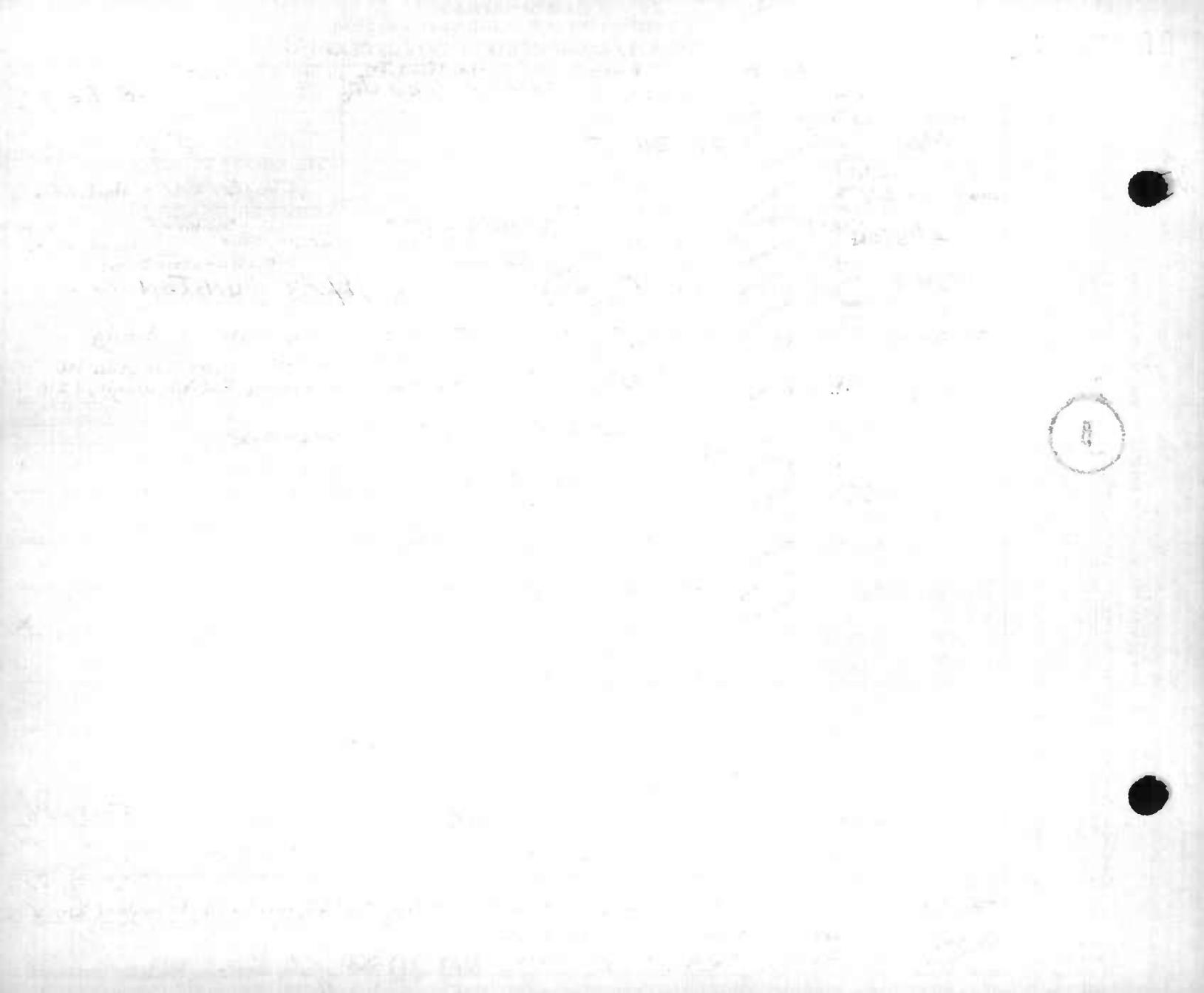
MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4080

| | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------------------------------------------------------------------------------|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------|----------------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST <u>James</u> | MIDDLE <u>Ralph</u> | LAST <u>Woodford, Jr.</u> | 2a. DATE KNOWN OF ESTI- DEATH MATED | MONTH <u>5</u> | DAY <u>18</u> | YEAR <u>86</u> | 2b. HOUR <u>6:20</u> |
| 3. SEX <u>MALE</u> | | RACE <u>White</u> | 4. RACE <u>White</u> | 5. DATE OF BIRTH MONTH <u>3</u> DAY <u>27</u> YEAR <u>36</u> | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. <u>50</u> | IF UNDER 1 YR. MONTHS <u></u> | IF UNDER 24 HRS. DAYS <u></u> | HOURS <u></u> | MIN. <u></u> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Philippi West Virginia USA</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> | | DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH <u>Fallston</u> (21014) | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS) <u>Fallston General Hosp</u> | | 12a. USUAL OCCUPATION <u>Retired</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Smithman</u> | | 12c. HOSPITAL DEPT. <u>Health Dept.</u> | |
| 13a. STATE <u>MD</u> | | 13b. COUNTY <u>HARFORD</u> | 13c. CITY OR TOWN <u>BEL AIR</u> | 13d. INSIDE CITY LIMITS? <u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <u>1403 GUNSTON ROAD</u> | | 14. FATHER'S NAME FIRST <u>Dr. JAMES</u> MIDDLE <u>Ralph</u> LAST <u>Woodford, Sr., M.D.</u> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>YES - Army</u> | | 16b. SOCIAL SECURITY NO. <u>1958-38-2241</u> | | 17. INFORMANT <u>Wife</u> ADDRESS <u>1403 GUNSTON RD</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Heart Disease</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. <u>19</u> MONTH <u></u> DAY <u></u> YEAR <u></u> P.M. <u></u> | | 21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21d. LOCATION STREET | |
| | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. LOCATION STREET | | CITY OR TOWN | | COUNTY | |
| 22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> | | and in my opinion | | | | | |
| ACTUAL SIGNATURE <u>Luis E. Renfro</u> | | TITLE (SPECIFY) <u>M.D. Deputy</u> | | MEDICAL EXAMINER | | DATE SIGNED <u>5-18-86</u> | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Luis E. Renfro MD</u> | | ADDRESS <u>464 Alliance St. Havre de Grace</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>May 21, 1986</u> | | 23c. NAME OF CEMETERY OR CREMATORIALY <u>Mt. Zion Methodist Cemetery</u> | | 23d. LOCATION CITY OR TOWN <u>BEL AIR</u> | | COUNTY <u>HARFORD</u> STATE <u>MD</u> | |
| 24. FUNERAL DIRECTOR <u>Joseph William Foster</u> | | ADDRESS <u>50 W. Broadway & Williams St.</u> | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 20 1986</u> | | 25b. REGISTRAR'S SIGNATURE <u>Julie Tueller Foster</u> | | | |
| BP _____ | | | | | | | | | |
| DHMH - 17 (VR A15 ME (5)) | | | | | | | | | |
| 15M 2/80 | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/Mental Hygiene permit. Then please remove certificate. Pages 1 & 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation.

IMPORTANT. If Home 21 is marked or Ham 18 shows continuity or other trouble

IMPORTANT

BP.

DHMH - 16 60M 7/84

(VRA 15-4)

MEDICAL CERTIFICATION

Funeral director, page 3
in 72 hours after death

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

198

| | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------|---------------|----------------|
| DECEASED NAME (TYPE OR PRINT) LAWRENCE | | | FIRST Lawrence | MIDDLE William | LAST Worthington | DATE OF DEATH MONTH 5 DAY 24 YEAR 86 | MONTH 11 | DAY 44 | YEAR AM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH 3 DAY 2 YEAR 20 | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS HOURS 0 MIN. 0 | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Havre de Grace, Md. | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Havre de Grace Md | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUP. FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp. | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | | | | 12b KIND OF BUSINESS OR INDUSTRY Dairy | | |
| SPECIAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | | | 13b. COUNTY Harford | 13c. CITY OR TOWN Havre de Grace | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 4001 Rock Run Rd / 21078 | | | |
| 14. FATHER'S NAME FIRST Littleton | MIDDLE Green | LAST Worthington | 15. MOTHER'S MAIDEN NAME FIRST Elizabeth | MIDDLE Viola | LAST Botts | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | 16b. SOCIAL SECURITY NO. 219 361 777 | 17. INFORMANT Mrs. Dorothy M. Worthington, 4001 Rock Run Rd. | ADDRESS Havre de Grace, Md. 21078 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)) Cardiac arrest | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF HTS CTP | | | | | | | | | |
| c) DUE TO, OR AS A CONSEQUENCE OF Pulmonary edema | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 5-24 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE J. F. Lee | | | DEGREE M.D. | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> | MEDICAL DIRECTOR <input type="checkbox"/> | STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGN'D 5/26 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. F. Lee | | | 22e. ADDRESS Clinton Medical Clinic | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE May 28, 1986 | 23c. NAME OF CEMETERY OR CREMATORIAL Cemetery | 23d. LOCATION CITY OR TOWN Churchville Presbyterian-Churchville - Harford - Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009 | ADDRESS ADDRESS | 25a. DATE REC'D. BY REGISTRAR MAY 28 1986 | 25b. REGISTRAR'S SIGNATURE John Davidson - Harford | | | | | | |

00-08477

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 4 0 8 2
REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, in medical examiner last filled in at direct

| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME FIRST MIDDLE LAST | | | | 2d. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
| <i>Alpha R. Wyatt</i> | | | | <i>May 30 1986</i> | <i>7:30 AM</i> |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| <i>FEMALE</i> | <i>WHITE</i> | <i>10 22 11</i> | <i>74</i> | 8. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | 10. CITY OR TOWN OF DEATH | |
| <i>N.C.</i> | <i>U.S.A.</i> | | <i>Harford</i> | <i>Harford</i> | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | |
| <i>Hartford Mem Hospital</i> | | | | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | |
| <i>MD</i> | <i>CECIL</i> | <i>Colona</i> | | <i>2790 Route Hwy.</i> | |
| 14. FATHER'S NAME | FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | |
| <i>Louis ROTEN</i> | | <i>NEANCY</i> | <i>NO</i> | | |
| | | | 16b. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
| <i>40</i> | <i>—</i> | | <i>245-48-6012</i> | <i>Willie Mae Barker</i> | <i>2747 Route Hwy. Colona MD.</i> |
| 18. CAUSE OF DEATH (Enter only one cause of death for part 1 or part 2) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE: | | | | | |
| <i>Acute coronary insufficiency</i> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Andere akut</i> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic cardiovascular disease</i> | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
| 22a. I certify that (b) (the hospital) attended the deceased from <i>5-26 86</i> , to <i>5-30 86</i> , that (b) (we) lost now the deceased patient on <i>5-30 1986</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (and did not) <input type="checkbox"/> the body after death. | | | | | |
| 22b. SIGNATURE | | | DEGREE | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22e. ADDRESS | |
| <i>H. Makinson M.D. 318 No. Union Ave. Holy Md 21078</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL ISPECIES | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORIAL | 23d. LOCATION CITY OR TOWN | 23e. COUNTY STATE | |
| <i>Burial</i> | <i>6-2-1986</i> | <i>NewBridge Bapt. St.</i> | <i>Colona</i> | <i>Cecil MD</i> | |
| 24. FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | |
| <i>Richard L. Goode</i> | <i>JUN 4 1986</i> | | | <i>Funeral Director</i> | |

